98th Congress
2d Session | COMMITTEE PRINT | S. PRT. 98-169
Vol. I

DEFICIT REDUCTION ACT OF 1984

EXPLANATION OF PROVISIONS APPROVED BY THE COMMITTEE ON MARCH 21, 1984

COMMITTEE ON FINANCE
UNITED STATES SENATE

Volume I

APRIL 2, 1984

U.S. GOVERNMENT PRINTING OFFICE
53-982 O WASHINGTON : 1984

For Sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

SUMMARY CONTENTS

VOLUME I:

VOLUME II:

DETAILED CONTENTS

VOLUME I:

I. LEGISLATIVE BACKGROUND OF FINANCE COMMITTEE DEFICIT REDUCTION PROVISIONS

1983 Committee Action

Provisions Included in S. 2062

The Senate Committee on Finance approved its fiscal year 1984 budget reconciliation recommendations on October 31, 1983, and transmitted bill and report language on that date to the Senate Committee on the Budget. The Budget Committee included the Finance Committee's revenue and spending reduction recommendations as title I (Deficit Reduction Act of 1983) of S. 2062 (Omnibus Reconciliation Act of 1983) as reported by the Budget Committee on November 4, 1983 (S. Rep. No. 98-300).

The Finance Committee budget reconciliation provisions in S. 2062 as reported included revenue increases of $13.4 billion over fiscal years 1984-1986 ($21.2 billion over fiscal years 1984-1987) and spending (outlay) reductions of $2.6 billion over fiscal years 1984-1986 ($4.1 billion over fiscal years 1984-1987).

S. 2062 was placed on the Senate Calendar and briefly considered on November 16, 1983, and was returned to the Calendar on November 18, 1983.

Additional 1983 Committee Consideration

Subsequent to the reporting of S. 2062, the Finance Committee met on November 16 and 18, 1983, to consider possible additional deficit reduction proposals. On November 18, 1983, the Committee approved a resolution to instruct the staffs of the Finance Committee and Joint Committee on Taxation, in consultation with the Treasury Department, to draft a deficit reduction package to reduce the projected budget deficit for fiscal years 1984-1987. The draft of the deficit reduction package was to be ready for Committee consideration by February 15, 1984.

The Finance Committee held public hearings on December 12-14, 1983, to receive further testimony on ways to reduce the Federal deficit.

1984 Committee Action

The Finance Committee began markup again on deficit reduction proposals on February 23, 1984, following public hearings on February 2 and 7, 1984, to receive testimony from the Aministration on their fiscal year 1985 budget proposal (submitted to the Congress on February 1, 1984). Also, a public hearing was held on February 8, 1984, to receive testimony concerning deficit reduction proposals made by the President's Private Sector Survey on Cost Control ("Grace Commission"). Finance Committee markup continued on February 28-29, and March 1, 7-8, 13-15, and 20-21, 1984, with the

Committee approval (by a recorded vote of 20-0 on March 21), of a deficit reduction proposal.

Following is a committee explanation of that proposal (revenue and spending reduction provisions), including estimated budget effects of the revenue and spending reduction provisions. Titles I-VIII are the revenue provisions, and title IX contains the spending reduction provisions.

sion to increase the authorization level for the Maternal and Child Health Block Grant program and a number of provisions without budgetary effect which modify various elements of the Medicare and Medicaid programs.

Additional items were added by the committee which deal with the Aid to Families with Dependent Children (AFDC) Program and the Supplemental Security Income (SSI) Program. For the most part, these provisions provide administrative simplification of technical clarifications for the Programs.

First, the committee agreed to a provision which would establish a standard filing or assistance unit for AFDC family. A related provision would require a minor parent of an AFDC child to remain with her own parent or legal guardian whenever possible. These provisions will not only target assistance to those with limited resources, but they will also simplify State administration of the program. Two additional technical amendments were approved, as well as a provision with negligible outlay effect. This provision permits States to exclude the earnings of a full time student from the eligibility determination calculation.

Second, the committee agreed to a provision which provides for the collection of windfall benefits from Supplemental Security Income benefits as well as from benefits paid under the Old Age Survivors and Disability Insurance programs. This provision is basically a technical correction to an amendment adopted in 1980.

4. Moratorium on Issuance of Fringe Benefit Regulations (sec. 829 of the bill)

Present Law

Moratorium

The Economic Recovery Tax Act of 1981 extended, through December 31, 1983, the legislative moratorium (first enacted in 1978) prohibiting the Treasury Department from issuing final regulations relating to the income tax treatment of nonstatutory fringe benefits. Also, the 1981 statute provided that no regulations relating to the treatment of such fringe benefits can be proposed which would be effective prior to expiration of the moratorium.

Employer-provided housing

Present law (Code sec. 119) excludes from an employee's gross income the value of lodging provided by the employer if (1) the lodging is furnished for the convenience of the employer, (2) the lodging is on the business premises of the employer, and (3) the employee is required to accept the lodging as a condition of employment. Several court decisions have held that on-campus housing furnished to faculty or other employees by an educational institution under the circumstances involved in those cases did not satisfy the section 119 requirements, and hence that the fair rental value of the housing (less any amounts paid for the housing by the employee) was includible in the employee's gross income and constituted wages for income tax withholding and employment tax purposes.[1]

Reasons for Change

Moratorium

The committee believes that a proper review of the important issues involved in the income and employment tax treatment of nonstatutory fringe benefits requires an additional period of time.

Faculty housing

The committee recognizes that certain court cases have upheld the Internal Revenue Service's position in those cases that the value of housing (including campus housing) provided by an employer at below fair market value to an employee, less amounts paid by the employee for the housing, is includible in income and wages. At the same time, in view of its extension of the moratorium on fringe benefit regulations to allow further study of the issues, the committee believes that it is appropriate that the moratorium be applied during the two-year extension period with respect to certain campus lodging furnished by an educational institution during the extension period.

Explanation of Provisions

a. Moratorium on fringe benefit regulations generally

The bill extends the legislative moratorium on issuance of fringe benefits regulations through December 31, 1985.

Under the bill, the Treasury Department (Internal Revenue Service) is prohibited from issuing prior to January 1, 1986 final regulations, under Code section 61, relating to the income tax treatment of nonstatutory fringe benefits. In addition, no regulations relating to the treatment of nonstatutory fringe benefits under section 61 are to be proposed which would be effective prior to January 1, 1986.

Although the provision of the bill relates only to the issuance of regulations, it is the intent of the Congress that the Treasury Department (Internal Revenue Service) will not in any significant way alter, or deviate from, the historical income-tax treatment of traditional nonstatutory fringe benefits through the issuance of revenue rulings or revenue procedures, etc. The bill does not prevent the Treasury or Revenue Service from continuing to study the question of the appropriate tax treatment of nonstatutory fringe benefits.

b. Faculty housing

Under the bill, the extended legislative moratorium is applied to prohibit the issuance of income tax regulations providing for the inclusion in gross income of the excess of the fair market value of qualified campus lodging over the greater of the operating costs paid in furnishing the lodging or the rent received. The term qualified campus lodging means lodging furnished by an educational institution (within the meaning of sec. 170(b)(1)(A)(ii))[2] to any employee of the educational institution (or to the employee's spouse or dependents), including non-faculty employees. The bill applies only if the employer-furnished lodging is located on a campus of, or in close proximity to, the educational institution. Under the bill, the moratorium does not apply with respect to any amount of the value of lodging if such amount was treated as wages or included in income when furnished.

---

[1] *Bob Jones University* v. *U.S.*, 670 F.2d 167 (Ct.Cl. 1982); *Goldsboro Christian Schools, Inc.* v *U.S.*, 79-1 CCH USTC para. 9266 (E.D.N.C. 1978) (value of lodging furnished to faculty constitutes wages subject to income tax, FICA, and FUTA withholding, in light of "long and consistent history of regulations and rulings, expressly and explicitly applying withholding taxes to lodging not furnished for the employer's convenience * * *"), aff'g order entered in *Goldsboro Christian Schools, Inc.* v. *U.S.*, 436 F.Supp. 1314 (E.D.N.C. 1977), aff'd per curiam in unpublished opinion (4th Cir. 1981), aff'd 103 S.Ct. 2017 (1983); *Winchell* v *U.S.*, 564 F.Supp. 131 (D.Neb. 1983) (value of campus home taxed to college president); and *Coulbourn H. Tyler*, 44 CCH Tax Ct. Memo. 1221 (1982).

[2] An educational organization is described in sec. 170(b)(1)(A)(ii) "if its primary function is the presentation of formal instruction and it normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on. The term includes institutions such as primary, secondary, preparatory, or high schools, and colleges and universities," and includes both public and private schools (Treas. Reg. sec. 1.170A-9(b)(1)).

Effective Date

The general extension of the legislative moratorium is effective on enactment. The application of the extended moratorium with respect to qualified campus lodging applies with respect to lodging furnished after December 31, 1983 and before January 1, 1986.

Revenue Effect

The provisions are estimated to reduce budget receipts by a negligible amount in each of fiscal years 1984, 1985, and 1986.

TITLE IX—SPENDING REDUCTION PROVISIONS

A. Medicare, Medicaid, and Other Health Provisions

1. Part B Premium (sec. 901 of the bill)

Present Law

By law, the Secretary of Health and Human Services has been required to calculate each December the increase in premiums of those who elect to enroll in the Supplementary Medical Insurance (or part B) portion of the Medicare program. The new premium rates have been effective on July 1 of the year following the year in which the calculation was made. Ordinarily, the new premium rate is the lower of: (1) an amount sufficient to cover one-half of the costs of the program for aged beneficiaries or (2) the current premium amount increased by the percentage by which cash benefits increased under the cost-of-living adjustment (COLA) provisions of the Social Security program. Premium income, which originally financed half of the costs of part B, had declined—as the result of this formula—to less than 25 percent of total program costs. The "Tax Equity and Fiscal Responsibility Act of 1982" (TEFRA) temporarily suspended the COLA limitation for two one-year periods, beginning on July 1, 1983. During these periods, enrollee premiums would be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. The limitation would again apply with respect to periods beginning July 1, 1985 and thereafter.

The "Social Security Amendments of 1983" (Public Law 98-21) postponed the scheduled July 1, 1983 increase to January 1, 1984 to coincide with the delay in the cost-of-living increase in social security cash benefit payments. Further increases will occur in January of each year based on calculations made the previous September. Public Law 98-21 further provided that the suspension of limitations as authorized by TEFRA is to apply for the two-year period beginning January 1, 1984, and ending December 31, 1985.

S. 2062

S. 2062 would extend for one year the existing temporary provision which fixes the proportion of the part B Medicare costs financed by enrollees at 25 percent of program costs for aged beneficiaries.

Modified Provision

The provision would permanently establish the premium rate at 25 percent of program costs for aged beneficiaries.

Effective Date

January 1, 1985.

Estimated Savings

Fiscal years:	Millions
1984	0
1985	0
1986	$384
1987	884
4-year total	$1,268

2. One-Month Delay In Medicare Entitlement (sec. 902 of the bill)

Present Law

Under current law, eligibility for Medicare begins on the first day of the month in which an individual reaches age 65. As a result, Medicare often pays benefits for services that were provided before an individual reaches his 65th birthday.

Explanation of Provision

The provision defers eligibility for parts A and B of Medicare until the first day of the month following the month the individual attains age 65.

The Committee believes that current private health benefits coverage can be extended to protect the large majority of people during the month in which they reach age 65. The Committee is concerned however that some people could find themselves with gaps in protection as a result of the provision. The Committee believes that State insurance authorities, which are the responsible governmental authorities for regulating private insurance contract provisions, will take such steps as may be necessary to assure that private policies will be amended or adjusted to assure continuity of coverage under such plans until Medicare coverage begins. The Committee also notes that Medicaid coverage will continue to be a available to needy aged individuals during the month before their Medicare coverage will begin.

The Committee directs the Secretary of HHS to make all reasonable efforts to inform individuals in advance of the date their Medicare coverage begins, and, to the extent feasible, make sure that these people do not suffer undue hardships as a result of the deferral of Medicare eligibility.

Effective Date

January 1, 1985.

Estimated Savings

Fiscal years:	Millions
1984	0
1985	$145
1986	230
1987	255
4-year total	$630

3. Modification of Working Aged Provision (sec. 903 of the bill)

Present Law

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) changed the Medicare benefits for the working aged. As of January 1, 1983, if the beneficiary so elects, Medicare benefits became secondary to benefits under an employer group health plan for employed individuals between the ages of 65 and 69. This provision applies to spouses only when both the employee and spouse are covered by an employer group health plan and both are between the ages of 65 and 69.

TEFRA does not allow Medicare to be the secondary payer if a beneficiary age 65 through 69 has a spouse under age 65 who is working and has an employer group health plan.

Explanation of Provision

The provision would modify both title XVIII and the Age Discrimination in Employment Act (ADEA) so as to eliminate the lower age limit for the working spouse. Under the provision a nonworking spouse aged 65 to 69 may elect primary coverage under the working spouse's employer group health plan even though the working spouse is not yet 65 years of age. If such an election is made, Medicare would become the secondary payer.

As modified the ADEA would require that any employer must provide that any employee's spouse aged 65 through 69 shall be entitled to coverage under any group health plan offered to such employee under the same conditions as any employee and the spouse of such employee under age 65.

Effective Date

January 1, 1985.

Estimated Savings

Fiscal years:	Millions
1984	0
1985	$260
1986	380
1987	415
4-year total	$1,055

4. Limitation on Physician Fee Prevailing and Customary Charge Levels; Participating Physician Incentives (sec. 904 of the bill)

Present Law

Under current law, Medicare pays for physician services on the basis of Medicare-determined "reasonable charges." "Reasonable charges" are the lesser of: a physician's actual charges, the customary charges made by an individual physician for specific services, or the prevailing level of charges made by other physicians for specific services in a geographic area. The amounts recognized by Medicare as customary and prevailing charges are updated annually (on July 1) to reflect changes in physician charging practices. Increases in prevailing charge levels are limited by an economic index which reflects changes in the operating expenses of physicians and earnings levels in general. The economic index limit promulgated for the period July 1, 1983 through June 30, 1984 represents an increase of 5.85 percent over the index utilized for the previous 12-month period.

S. 2062

The bill provided that the prevailing charge level which was in effect prior to the annual updating which occurred on July 1, 1983 would be utilized for the December 1, 1983–June 30, 1984 period. Thus, for this seven month period until July 1, 1984, prevailing charge limits for all physician service would have reverted to the levels applicable during the July 1, 1982–June 30, 1983 fee screen year. Physicians' customary charge screens would not have been affected by the rollback.

Modified Provision

The provision would freeze all customary and prevailing fees for physician services one year beginning July 1, 1984. The freeze would be continued for an additional year for the prevailing fees of physicians who are not willing to accept assignment on all Medicare claims. No catch-up would be permitted for fees which were frozen.

In conjunction with the freeze, a voluntary participating system would be established for Medicare, similar to the participation physician agreements successfully used by some Blue Shield plans in their private business. Under a physician participating system, physicians would sign an agreement indicating their willingness to accept assignment for all services provided to all Medicare patients for the following fee screen year (July 1, 1985 to June 30, 1986). By agreeing to accept assignment in advance for all services for all Medicare patients, the physician would agree to accept the Medicare determined allowance as payment in full except for cost-sharing amounts. The physician would bill the carrier directly and receive payment from the carrier.

The current assignment system would remain for physicians who did not voluntarily sign a participation agreement, i.e., nonparticipating physicians could continue to accept assignment on a claim-by-claim basis. As under the current system, assignment must be accepted for joint Medicaid-Medicare eligibles.

A voluntary participation physician system would allow Medicare beneficiaries to better predict out-of-pocket expenses since, as noted below, they would know in advance which physicians participate (i.e., always accept assignment). A voluntary system would not compel any physician to participate and the current claim-by-claim assignment system would be preserved for non-participating physicians.

Several incentives would be used to encourage physician participation. These include:

(1) Physician and Supplier List.—Similar to the provision already agreed to by the Committee, one incentive would require that lists of physicians and suppliers be published containing the name, ad-

dress, phone number, specialty and an indication of volume of assigned versus total Medicare claims or reimbursements in the previous year for each physician and supplier. Low-volume physicians or supplies could be excluded from the list. In the case of physicians who practice solely as staff members of a health maintenance organization or other similar associations, the Secretary may choose to list the name of the organization and its Medicare assignment data information.

These lists would be published annually with carrier discretion as to the appropriate geographic level to make them most meaningful for beneficiary use. A check stuffer would be sent to all Medicare beneficiaries notifying them about the availability of the lists. The lists would be provided to senior citizen groups and would be made available for beneficiaries to review at both carrier and Social Security District and Branch offices. The Secretary would be directed to make arrangements to make such lists available for purchase by organizations and individuals. In addition to this list there would also be prepared a directory containing the names of only those physicians and suppliers who agree to be "participating" physicians and suppliers.

(2) Toll-free hot lines.—The system of toll-free hot-lines already in place at the carriers would be expanded. Carriers would hire additional staff to (a) provide names, addresses, phone numbers and specialties of participating physicians and suppliers, and (b) confirm whether specified physicians participated.

(3) Electronic Billing Transmission Lines.—Currently about 13 percent of Medicare claims are transmitted to carriers by a variety of electronic/automatic mechanisms, including tape-to-tape, floppy disks, etc. As an incentive to become a participating physician, carriers could establish direct lines for the electronic receipt of claims from participating physicians. Non-participating physicians would be permitted to continue to transmit claims electronically.

(4) For beneficiaries with approved Medigap coverage, or with group health insurance plans which serve as Medigap policies, two simplified billing/payment arrangements would be available. Carriers could use either or both.

(a) Piggyback Billing.—Under this arrrangement, the physician or supplier submits one bill to the carrier. The carrier pays the physician or supplier the Medicare reimbursement and then sends willing Medigap insurors information on the amount paid. The Medigap insuror would automatically pay the physician or supplier for the beneficiary's cost-sharing liabilities. The physician or supplier would not need to submit a separate bill to the beneficiary or the Medigap plan for the cost-sharing and the beneficiary would be removed from the paperwork payment process. In order to avail itself of this option, the supplemental plan would have had to provide its eligibility file to the carrier. To the extent feasible, Medicaid could also make use of piggyback billing.

(b) Payment to organizations.—Under this arrangement, the participating physician or supplier would submit one bill to the Medigap insuror. The Medigap insuror would pay the physician or supplier an amount which the physician or supplier accepts as payment-in-full, including cost-sharing liabilities. (The Medigap plan may pay the physician or supplier more than the Medicare reasonable charge.) The Medigap plan would then collect the reasonable charge from Medicare. Only one bill would be submitted by the physician or supplier and one check would be paid to the physician or supplier. The beneficiary would not be responsible for paying the physician or supplier or collecting from the Medicare carrier or the Medigap plan.

Effective Date

July 1, 1984.

Estimated Savings

Fiscal years:	*Millions*
1984	$40
1985	760
1986	910
1987	1,070
4-year total	$2,770

5. Limitation on Increase in Hospital Costs per Case (sec. 905 of the bill)

Present Law

The "Tax Equity and Fiscal Responsibility Act of 1982" (Public Law 97-248, commonly referred to as TEFRA) expanded previously existing limits on Medicare costs effective October 1, 1982. Among other things, it established a 3-year target rate reimbursement system which in effect limited allowable rates of increase in Medicare payments per case over the fiscal year 1983-1985 period. The target rate is equal to the previous year's allowable operating costs per case (or after the first year, the previous year's target amount) increased by the percentage increase in the hospital wage and price index (market basket) plus one percentage point. Penalties and bonuses were established for hospitals, with costs above and below the target.

The "Social Security Amendments of 1983" (Public Law 98-21) provides for the establishment of a prospective payment system for hospitals to be phased-in over a 3-year period. During the transitional period a portion of a hospital's payments will be based on prospective rates and a portion on each hospital's own cost base. The cost-based portion of the payment will be calculated on the basis of reasonable costs, subject to the existing rate of increase limits, without the penalties and bonuses established under TEFRA.

In addition, under current law the rates for each DRG, like the cost-based costs per case, are derived from historical Medicare cost data for each hospital. For fiscal years 1984 and 1985, payment amounts from the previous fiscal years would be increased by the market basket, plus one percentage point. For fiscal years beginning on or after October 1, 1986, the rate of increase is left to the discretion of the Secretary.

Explanation of Provision

The provision would, for two years, (fiscal years 1985 and 1986), limit the rate of increase in the hospital cost portion of the payment amounts to the market basket minus one-half percentage point. The rate of increase in the DRG portion of the payment amounts would be limited during the same two years to the market basket plus one-half percentage point. Exempted hospitals and hospital units would be subject to similar rate of increase limitations applicable to their costs . . . (MB−½ and MB+½) in the same proportion as hospitals under the prospective payment system with the same accounting years. This would result in a rate of increase for exempted hospitals of MB in the first year and MB +¼ in the second year.

Effective Date

Accounting years beginning on or after October 1, 1984 and before October 1, 1986.

Estimated Savings

Fiscal year:	Millions
1984	0
1985	$190
1986	430
1987	460
4-year total	$1,080

6. Fee Schedule for Clinical Laboratory Services (sec. 906 of the bill)

Under current law, outpatient diagnostic laboratory services are reimbursed on the basis of reasonable charges when furnished by an independent laboratory or by a physician. Payment for such services to hospital outpatients is on the basis of reasonable cost. These laboratory services are covered under part B of the Medicare program; thus, the beneficiary is subject to the part B deductible and coinsurance requirements.

S. 2062

The bill would establish fee schedules for all laboratory services other than hospital-based laboratory services. Payments would be based on a fee schedule unless the actual charge is lower. The schedule would be established for two years for areas to be designated by the Secretary.

The initial payment level for each fee schedule would have been established at 65% of prevailing charges in the area for the fee screen year beginning July 1, 1983. The Secretary would be required to adjust the fee schedules annually to reflect changes in the Consumer Price Index for all Urban Consumers (U.S. city average).

All clinical laboratories would have been required to bill the Medicare program or beneficiaries directly, for the tests they perform rather than billing the physician who ordered the tests (laboratories performing tests "under arrangement" with a hospital could continue to bill the hospital for hospital outpatients). Physicians would be permitted to bill for clinical laboratory services only when the physician directly provides, or supervises the provision of, clinical laboratory services.

The bill provided that acceptance of assignment for the performance of laboratory services is optional for both clinical laboratories and physicians. Where either accepts assignment, reimbursement would be made at 100 percent of the fee schedule amount (or, if lower, the billed charge), with the deductible and coinsurance waived.

Laboratories and physicians not accepting assignment would have continued to be reimbursed at 80 percent of the fee schedule amount or if lower, 80 percent of the billed charge; applicable deductible and coinsurance amounts would continue to apply.

The bill directed the Secretary to simplify current billing requirements for laboratory services.

The bill further required the Secretary to report to the Congress by June 30, 1985 on the appropriate treatment of hospital-based laboratories, direct payment of all lab fees to physicians, the basis for the formulation of a nationwide fee schedule, and an appropriate indexing mechanism for such a schedule.

Modified Provision

The provision requires the establishment of a fee schedule for all noninpatient laboratory services, including those furnished by hospital outpatient departments. The level of payment would be set at 60 percent of the prevailing charge levels (applicable during the fee screen year beginning July 1, 1983) for services provided by independent labs and in physicians' offices. The level of payment for hospital-based labs would be set at 62 percent of these prevailing charge levels.

These fee schedules would be in effect from May 1, 1984 until September 30, 1987.

Under the provision, the Secretary may make adjustments or exceptions to the fee schedule to assure adequate reimbursement of: (1) emergency laboratory tests needed for the provision of bona fide emergency services in a hospital emergency room; and (2) certain low volume high-cost tests where highly sophisticated equipment and extremely skilled personnel are necessary to assure quality.

The other provisions previously contained in S. 2062 relating to assignment and billing requirements would be retained as would the requirement that the Secretary report to the Congress. However, the provision makes permanent the requirement that only those actually performing the tests or supervising the tests bill the program. In the case of an unassigned claim the beneficiary may continue to submit the bill.

Effective Date

May 1, 1984.

Estimated Savings

Fiscal year:	Millions
1984	$70
1985	255

1986	320
1987	400
4-year total	$1,045

7. Revaluation of Assets (sec. 907 of the bill)

Present Law

Medicare currently reimburses hospitals for their capital-related costs, including depreciation costs and interest. Investor-owned hospitals also receive a return on equity.

When hospitals are sold, their assets are often revalued, thereby increasing reimbursement for these capital-related costs.

Explanation of Provision

The provision would limit any increase in capital-related cost reimbursement to a new owner that would result from the revaluation of hospital assets acquired in fiscal year 1985 and thereafter. The capital-related cost of the new owner would be based on the acquisition cost of the asset as entered on the books of the prior owner less any depreciation taken on the asset by the prior owner. In addition, the new owner's capital-related costs must be determined using the same useful life and method of depreciation as used by the prior owner for reimbursement under the Medicare program.

Effective Date

Acquisitions made on or after October 1, 1984.

Estimated Savings

Fiscal year:	Millions
1984	0
1985	$50
1986	110
1987	170
4-year total	$330

8. Repeal of Preadmission Diagnostic Testing Provision (sec. 908 of the bill)

Present Law

The Omnibus Reconciliation Act of 1980 (Section 932 and 942) authorized 100 percent Part B reimbursement (on a reasonable cost or charge basis) for preadmission diagnostic testing, either in a hospital's outpatient department or in a physician's office, within seven days prior to a hospital admission. This provision was intended to encourage preadmission testing and shorten hospital stays, thus decreasing overall Medicare payments.

The final regulation implementing 100 percent reimbursement for preadmission testing in hospital outpatient departments was not published because of subsequent hospital reimbursement

changes in the Social Security Amendments of 1983. (The regulation covering physician's offices has not been developed.)

Explanation of Provision

The provision would repeal the provision providing for 100 percent reimbursement and simply pay for these services on the same basis as all other services under part B (80 percent).

The Committee believes that given the incentives created by the new prospective payment system, hospitals already have every reason to do their testing on an outpatient basis.

Effective Date

Enactment.

9. Skilled Nursing Facility Reimbursement (sec. 909 of the bill)

Present Law

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) required the Secretary to establish a single payment limit for both freestanding and hospital-based skilled nursing facilities (SNFs), effective October 1, 1982. Prior to that time, separate limits were established for these two types of facilities in recognition of the fact that the operating costs of hospital-based facilities were typically much higher than those of the freestanding facilities.

In the Social Security Amendments of 1983 (P.L. 98-21), the effective date of the single-limit requirement was postponed for one year. In addition, the Congress required the Secretary to report by December 31, 1983 on the effect of the implementation of the TEFRA single-rate provision on hospital-based SNFs, given the difference (if any) in the patient populations served by such facilities and by freestanding SNFs. Further, the Secretary was required to report by the end of 1983 on the impact of hospital prospective payment on SNFs.

S. 2062

The bill postponed implementation of the single rate for SNFs until April 1, 1984. The Committee believed it prudent to wait until the Secretary completed the report on hospital-based SNFs before implementing the single-rate provision.

Modified Provision

(1) For fiscal year 1983 and until July 1, 1984, hospital based facilities and freestanding facilities would be paid on the basis of the policy for calculating reimbursement limits that had been in effect prior to the passage of TEFRA. Under this system, the limits for freestanding facilities would be set at 112 percent of the average per diem operating costs for urban and rural facilities, respectively. The limits for hospital-based facilities would similarly be set at 112 percent of the average per diem operating cost for urban and rural hospital based facilities, respectively.

(2) Effective July 1, 1984 and thereafter, the Secretary would establish dual limits for hospital-based and freestanding SNFs on a

somewhat different basis. Separate limits would continue to be established for freestanding facilities in urban and rural areas at 112 percent of the mean operating costs of urban and rural freestanding facilities, respectively. However, limits for urban or rural hospital-based facilities would be set at the appropriate freestanding facility limit plus 50 percent of the difference between the freestanding facility limit and 112 percent of mean operating costs for hospital-based facilities. Cost differences between hospital-based and free-standing facilities attributable to excess overhead allocations resulting from medicare reimbursement principles shall be recognized as an add-on to the limit. Adjustments would be made to take account of differences in wage levels prevailing in a facilities area.

Under this provision, both hospital based and freestanding facilities could continue to apply for and receive exceptions from the cost limits in circumstances where high costs result from more severe than average case mix or circumstances beyond the control of the facility. Indicators of more severe casemix include a comparatively high proportion of Medicare days to total patient days, comparatively high ancillary costs, or relatively low average length of stay for all patients (an indicator of the rehabilitative orientation of the facility). Facilities eligible for exceptions could receive, where justified, up to all of their reasonable costs.

(3) The Secretary shall forward to the Congress, no later than April 15, 1984, the final report on skilled nursing facilities as required by TEFRA.

(4) The Secretary shall submit, no later than December 1, 1984, a proposal for implementation of a prospective payment system for skilled nursing care under Part A. Such payment system shall take into account case mix differences between providers. Such a system should also be designed so as to permit the inclusion of payments into the payments currently made to hospitals under the DRG system. The proposal shall be drafted so as to be implementable as of October 1, 1985.

Effective Date

October 1, 1983.

Estimated Cost

Fiscal year:	Millions
1984	$20
1985	30
1986	35
1987	40
4-year total	$125

10. Rounding of Part B Payments (sec. 910 of the bill)

Present Law

The Omnibus Budget Reconciliation Act of 1981 authorized the Social Security Administration (SSA) to round to the next lower whole dollar payments made after July 31, 1981 to beneficiaries of Title II of the Social Security Act (Federal Old Age, Survivors and Disability Insurance).

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) expanded the use of the "round-down" concept to two other programs administered by SSA. Under the Aid to Families with Dependent Children (AFDC) program, States are required to round both their AFDC need standard and actual monthly benefit amounts to the next lower whole dollar. Under the Supplemental Security Income (SSI) program, both the monthly benefit and income eligibility amounts are to be rounded to the next lower whole dollar.

Neither the Omnibus Budget Reconciliation Act nor TEFRA incorporated the "round-down" concept into Medicare reimbursement. Medicare carriers continue to compute payments to physicians and suppliers, or beneficiaries in the case of unassigned claims, to the nearest penny.

Explanation of Provision

The provision would require Medicare part B charge based payments on claims that are not whole dollar amounts to be rounded down to the next lower dollar. Physicians and suppliers accepting assignment could not bill the beneficiary for amounts lost through rounding.

Effective Date

July 1, 1984.

Estimated Savings

Fiscal year:	Millions
1984	$15
1985	65
1986	70
1987	75
4-year total	$225

11. Agreements for Medicare Claims Processing (sec. 911 of the bill)

Present Law

Under current law, Medicare contracts with intermediaries and carriers to perform the day-to-day operational work of the program including reviewing claims and making program payments.

Explanation of Provision

The provision would increase the Secretary's discretion in entering into agreements for Medicare claims processing by (1) eliminating the right of providers of services to nominate intermediaries, (2) permitting the Secretary to enter into various kinds of agreements, not solely those based on cost, and (3) broadening the Secretary's authority to experiment with different kinds of contracts by including contracts other than fixed price or performance incentive contracts and by permitting waiver of competitive bidding requirements. The provision also allows the Secretary to provide for publi-

cation of the standards for contractors through normal administrative issuances rather than through the regulatory process.

Effective Date

October 1, 1984.

Estimated Savings

Fiscal year:	Millions
1984	0
1985	$15
1986	25
1987	35
4-year total	$75

12. Lesser of Cost or Charges (sec. 912 of the bill)

Present Law

Current law includes provisions for Medicare to pay providers the lesser of costs or charges (LCC). These provisions were adopted (before hospital prospective payment) to assure that Medicare would not pay providers more than the amounts paid by the general public. HCFA regulations allow hospitals to calculate the amount of their costs and charges in the aggregate for inpatient and outpatient services. This policy has the effect of permitting hospitals with low outpatient charges to nevertheless receive their full costs from Medicare by adding in their typically above-cost inpatient charges.

Explanation of Provision

The provision would require the Secretary to issue regulations to isolate the calculation of the lesser of costs or charges for outpatient services from the calculation for inpatient services.

Effective Date

Accounting periods beginning on or after October 1, 1984.

Estimated Savings

Fiscal year:	Millions
1984	0
1985	$80
1986	90
1987	105
4-year total	$275

13. Hepatitis B Vaccine (sec. 913 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Present law precludes Medicare coverage of immunizations and vaccines with the exception of the pneumococcal vaccine. Therefore, the program does not cover immunizations against viral hepatitis, and infectious disease that produces acute and chronic inflamation of the liver which may lead to serious illness or death.

End stage renal disease (ESRD) patients are currently monitored by monthly testing for the virus, and these tests are covered and paid for under Medicare.

Explanation of Provision

The provision covers Hepatitis B vaccine under Medicare for ESRD hemodialysis patients.

The Committee has given the Secretary the flexibility to develop a payment method that may be different from the usual Medicare reimbursement rules. In developing such a payment system, the Committee believes that any payment system should provide a payment amount which reasonably reflects the cost of efficiently providing and administering the vaccine. We would also recommend that the Secretary revise coverage guidelines with respect to the frequency of Hepatitis B testing for successfully immunized patients.

Effective Date

July 1, 1984.

Estimated Savings

Fiscal year:	Millions
1984	−$3
1985	1
1986	2
1987	2
4-year total	$2

14. Limitation on Certain Foot Care Services (sec. 914 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Routine foot care is not covered under the Medicare program; however, Medicare does allow reimbursement to physicians for debridement of mycotic toenails (toenails with fungal infection) which should not be performed by a nonprofessional.

There has been considerable concern regarding the frequency with which this procedure is taking place. The Health and Human Services Inspector General conducted a review in Virginia and concluded that this benefit was being abused because the procedure was being performed more frequently than necessary and was being performed on patients (particularly nursing home patients) who did not require professional care.

Explanation of Provision

The provision would require the Secretary to issue regulations establishing coverage guidelines under the Medicare program for debridement of mycotic toenails. Unless the Secretary determines otherwise, no payment would be made for such services where per-

formed more frequently than once every 60 days. Exceptions could be authorized if medical necessity were documented by the physician.

Effective Date

Services furnished on or after enactment.

Estimated Savings

Fiscal year:	Millions
1984	$5
1985	11
1986	11
1987	12
4-year total	$39

15. Coverage of Hemophilia Clotting Factor (sec. 915 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Present law excludes coverage of drugs and biologicals unless they are of the type that cannot be self-administered and are commonly furnished incident to physicians services.

Hemophilia is a life-long disease in which a patient whose blood lacks a clotting factor is subject to spontaneous hemorrhages. In the past 13 years hemophilia patients have had the benefit of a human blood derived concentrate which, when infused, induces the blood to clot, and when appropriately given in advance may prevent bleeding.

The hemophilia clotting factor is considered to be a biological under Medicare and is covered when provided by a physician to a patient, on either an inpatient or outpatient basis.

Explanation of Provision

The provision would permit Medicare coverage for the supplies and products necessary for the self-administration of the clotting factor, subject to utilization controls deemed necessary by the Secretary for the efficient use of the factors.

Effective Date

Items and services purchased on or after enactment.

Estimated Savings

Negligible.

16. Indexing of Part B Deductible (sec. 916 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under present law, enrollees in the Supplementary Medical Insurance (or Part B) portion of Medicare must pay the first $75 of

covered expenses (known as the deductible) each year before any benefits are paid. The amount of this deductible is fixed by law.

Explanation of Provision

The provision would index the amount of the Part B deductible for 3 years beginning in calendar year 1985, by the percentage by which the Medicare economic index increases each year. The Medicare economic index is the index used to limit increases in the prevailing level of physician fees reimbursable under the Part B program. It is estimated that the deductible would increase to $78 in calendar year 1985, $82 in calendar year 1986, and $86 in calendar year 1987, and then remain at that level.

Effective Date

January 1, 1985.

Estimated Savings

Fiscal year:	Millions
1984	0
1985	$35
1986	90
1987	100
4-year total	$225

17. Cost Sharing for Durable Medical Equipment Furnished as a Home Health Benefit (sec. 917 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under present law, when covered durable medical equipment (DME) is furnished to an outpatient by a supplier of services or by an institutional provider, payment is made under the Part B program on the basis of 80 percent of the reasonable charges or 80 percent of the reasonable costs, with one exception. If the equipment is furnished by a home health agency, payment is made on the basis of 100 percent of the reasonable cost.

Explanation of Provision

The provision would reimburse home health agencies for durable medical equipment at 80 percent of reasonable cost and as in the case of other providers and suppliers, permit the agencies to bill beneficiaries for the remaining 20 percent.

Effective Date

Items or services furnished on or after enactment.

Estimated Savings

Fiscal year:	Millions
1984	$10
1985	20
1986	25
1987	25
4-year total	$80

18. Extension of Medicaid Payment Reductions and Offsets (sec. 921 of the bill)

Present Law

Public Law 97-35 provided that whatever Federal matching payments a State is otherwise entitled to are to be reduced by 3 percent in fiscal year 1982, 4 percent in fiscal year 1983, and 4.5 percent in fiscal year 1984. A State may qualify for a percentage point offset to these reductions of up to 3 percent if it has a qualified hospital cost review program, an unemployment rate which exceeds 150 percent of the national average, or fraud and abuse recoveries greater than one percent of Federal expenditures. In addition States may earn back part or all of the reductions if expenditures remain below specific target amounts.

Explanation of Provision

This provision would extend the existing reduction and offset provisions for 3 years. The reduction rate would be 3 percent for fiscal years 1985, 1986 and 1987. Moreover, for the purpose of determining the amount of payments under subsection 1903(a)(1)(A) that a State is otherwise entitled to receive for a given fiscal year, interest paid under subsections 1903(d)(2) and 1903(d)(5) and adjustments under section 1128A are to be excluded under certain circumstances.

Effective Date

October 1, 1984.

Estimated Savings

Fiscal year:	*Millions*
1984	0
1985	$562
1986	353
1987	432
4-year total	$1,347

19. Mandatory Assignment of Rights of Payment by Medicaid Recipients (sec. 922 of the bill)

Present Law

States are now permitted to require Medicaid applicants to assign to the State their rights to medical support and third party payments for medical care. Approximately 25 States have taken advantage of this provision.

Explanation of Provision

This provision would mandate that States require Medicaid applicants to assign to the State their rights to third party payments as a condition of eligibility.

Effective Date

October 1, 1984. A later implementation date is permitted when State legislation is required.

Estimated Savings

Fiscal year:	*Millions*
1984	0
1985	$7
1986	7
1987	8
4-year total	$22

20. Increase in Medicaid Ceiling Amount for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa (sec. 923 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Current law authorizes participation of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in the Medicaid program. It sets the Federal matching rate for these jurisdictions at 50% and provides for annual ceilings on such payments of $45 million for Puerto Rico, $1.5 million for the Virgin Islands, $1.4 million for Guam, $350,000 for the Northern Mariana Islands, and $750,000 for American Samoa.

Explanation of Provision

The provision would increase the annual dollar ceilings on Federal payments to these jurisdictions. The new ceilings would be $63.4 million for Puerto Rico, $2.1 million for the Virgin Islands, $2.0 million for Guam, $550,000 for the Northern Mariana Islands, and $1,150,000 for American Samoa.

Effective Date

October 1, 1983.

Estimated Cost

Fiscal year:	*Millions*
1984	$20
1985	20
1986	20
1987	20
4-year total	$80

21. Increase Authorization for Maternal and Child Health Block Grant Program (sec. 924 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

The present law authorizes $373 million for the Maternal and Child Health (MCH) Block grant program. Congress appropriated an additional $105 million for the program in fiscal year 1983 under Public Law 98-8 and an additional $26 million in fiscal year 1984.

Explanation of Provision

The provision would permanently increase the authorization level for the MCH block grant program. The level would be increased to $452 million in fiscal year 1984, $453 million in fiscal year 1985, and $455 million in fiscal year 1986 and thereafter.

Effective Date

October 1, 1983.

Estimated Cost

Fiscal year:	Millions
1984	$33
1985	30
1986	12
1987	−14
4-year total	$61

22. Medicaid Coverage for Pregnant Women (sec. 925 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Prior to the enactment of the "Omnibus Budget Reconciliation Act of 1981" (Public Law 97-35) States were permitted to allow pregnant women to qualify for AFDC payments on the basis of their unborn children. Pregnant women who are entitled to AFDC cash payments on this basis were also entitled to Medicaid coverage. Public Law 97-35 prohibited States from making AFDC cash payments to a pregnant woman on the basis of her unborn child until the sixth month of pregnancy. However, States are permitted to extend Medicaid eligibility to these women from the time the pregnancy has been medically verified. An estimated 80 percent of the States and jurisdictions have elected to provide Medicaid coverage to a pregnant woman on the basis of her unborn child for either all or a portion of her pregnancy.

Explanation of Provision

The provision would mandate States to provide Medicaid coverage beginning with the medical determination of pregnancy to

every woman who would be eligible for AFDC if the child were born.

Effective Date

July 1, 1984. A later implementation date is permitted when State legislation is required.

Estimated Cost

Fiscal year:	Millions
1984	$1
1985	11
1986	12
1987	13
4-year total	$40

23. Recertification of SNF/ICF Patients (sec. 926 of the bill)

(Contained in S. 2062 as originally reported)

a. Present Law

Under current Medicaid law, a State's evidence of a satisfactory program of controls over utilization must include evidence that physicians recertify the need for continuing skilled nursing facility (SNF) and intermediate care facility (ICF) services every 60 days. However, there is evidence that less frequent recertification may be more appropriate in the case of long term intermediate care facility stays.

Explanation of Provision

The provision would modify the current physician recertification schedule. For skilled nursing facilities the following schedule would be established:

30 days after initial admittance;
60 days after initial admittance;
90 days after initial admittance;
60-day intervals thereafter.

For intermediate care facilities, the following schedule would be established:

60 days after initial admittance;
120 days after initial admittance;
12 months after initial admittance;
18 months after initial admittance;
24 months after initial admittance;
1-year intervals thereafter.

b. Present Law

Current law requires 100 percent on-time compliance with physician recertification requirements.

Explanation of Provision

The provision permits a ten day grace period if a State demonstrates good cause for physicians not meeting the deadline.

c. Present Law

By law, the quarterly Federal penalty imposed on States for failure to have an adequate program of controls over utilization is equal to 33⅓ percent muitiplied by a ratio of all Medicaid patients in facilities with one or more surveyed records out of compliance to all Medicaid patients in those types of facilities.

Explanation of Provision

The provision would modify the existing formula by substituting 5 percent for the existing 33⅓ percent figure. Further, the provision would specify that no penalty would be imposed in cases where the total number of patients whose records were surveyed and found out of compliance is less than 3 percent of the total number of patients included in the survey.

Effective Date

Quarters beginning on or after enactment.

Estimated Savings

Fiscal year:	Millions
1984	$3
1985	4
1986	0
1987	−1
4-year total	$6

24. Study of Physician Reimbursement for Cognitive Services (sec. 931 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Medicare payments to physicians are made on the basis of reasonable charges for specific services. There is concern that the existing payment methodology may result in payment imbalances between various physician specialties, types of procedures, and health care settings. The current reimbursement system rewards physicians for their technical skills and for the performance of certain activities such as surgery or diagnostic tests. As a result, there is concern that the system discourages physicians from spending time with patients to counsel or examine them.

Explanation of Provision

The provision directs the Office of Technology Assessment, in consultation with appropriate physician organizations and the Secretary, to conduct a study examining any imbalance in payments to physicians for their cognitive vs. their technical services. It is the desire of the Committee that the OTA study results include specific recommendations on ways to modify the existing system for determining Medicare allowances to eliminate any inequities that exist between reimbursement levels for medical procedures and cognitive services.

OTA is also directed to include specific findings and recommendations on creating a means to adjust allowances to physicians as the costs and risks to physicians, which result from new technologies and procedures, decrease over time. The provision requires submission of the report to Congress by December 31, 1985.

Effective Date

Enactment.

25. Elimination of Part B Deductible for Certain Diagnostic Laboratory Tests (sec. 932 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Present law authorizes the Secretary to negotiate with a laboratory a payment rate that is considered the full charge for diagnostic tests. The payment, which is made directly to the laboratory, equals 100 percent of the negotiated rate subject to the annual Part B deductible. The beneficiary is not liable for the 20-percent coinsurance payment that usually is applicable.

Explanation of Provision

The provision eliminates application of the annual Part B deductible in the case of diagnostic tests performed in a laboratory which has entered into a negotiated rate agreement with the Secretary. Should the fee schedule provision proposed in a separate section of this bill not be extended beyond September 30, 1987, this provision would then provide an incentive for laboratories to enter into such agreements and thereby reduce costs associated with individual billing of Medicare beneficiaries.

Effective Date

Diagnostic tests performed on or after September 30, 1987.

26. Payment for Services Following Termination of Participation Agreements With Home Health Agencies and Hospices (sec. 933 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under current law, if Medicare participation of a home health agency or a hospice is terminated, the Secretary is required to continue to pay for services provided to a beneficiary until the end of the calendar year in which the termination took place. This requirement is only applicable to services provided under an individual plan of care established prior to the termination of the agency.

Explanation of Provision

The provision changes from the end of the calendar year to 30 days after termination, the ending of coverage for services provided

under a plan established prior to the termination date of the participation agreement. This provision brings the treatment of home health agencies and hospices into conformity with the treatment of hospitals and skilled nursing facilities.

Effective Date

Enactment.

27. Repeal of Special Tuberculosis Treatment Requirements Under Medicare and Medicaid (sec. 934 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Present law contains a number of provisions intended to assure that institutional services provided to Medicare and Medicaid patients suffering from tuberculosis are not custodial in nature and that such treatment can reasonably be expected to improve the patient's condition or render the condition noncommunicable.

Explanation of Provision

The provision repeals the special provisions. Advances in the active treatment of tuberculosis make such safeguards against paying for custodial care for tuberculosis patients unnecessary. The provision also eliminates tuberculosis hospitals as a special provider category in the Medicare and Medicaid programs.

Effective Date

Enactment.

28. Medicare Recovery Against Certain Third Parties (sec. 935 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under current law, the Medicare program may make payments for services for which other third party insurance programs (e.g., worker's compensation, auto or liability insurance, and employer health plans) are ultimately liable for some or all of the costs. However, the Secretary does not now have the right of subrogation to become a party to claims against other liable parties or to recover directly from such parties.

Explanation of Provision

The provision establishes the statutory right of Medicare to recover directly from a liable third party, on behalf of a beneficiary, if the beneficiary himself does not do so, and to pay the beneficiary or a health care provider or supplier on the beneficiary's behalf, pending recovery where such third party is not expected to pay promptly. These provisions are intended to improve the ability of

the Medicare program to obtain reimbursement to which it is entitled by law.

Effective Date

Enactment.

29. Indirect Payment of Supplementary Medical Insurance Benefits (sec. 936 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Current law does not, in general, permit Medicare Part B payments to be made to anyone other than a beneficiary or an entity providing services.

Explanation of Provision

The provision permits Part B payments to be made to a health benefits plan whose payment, in combination with the Medicare payment, is accepted by the physician or other supplier as payment in full. The purpose of this provision is to enable this indirect payment procedure to be available to non-group as well as group, health benefit plans such as those offered by employers, unions, insurance companies, and other organizations.

Effective Date

Enactment.

30. Elimination of Health Insurance Benefits Advisory Council (sec. 937 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Section 1867 of the Social Security Act provides for a 19 member panel of health experts (the Health Insurance Benefits Advisory Council or HIBAC) appointed by the Secretary to advise on matters of general policy with respect to the Medicare and Medicaid programs.

Explanation of Provision

The provision repeals Section 1867. HIBAC was very active in the early years of the Medicare program when regulations were first promulgated. As the Federal Government gained experience in administering the Medicare program, the Council's advisory functions with respect to regulations became less important. With passage of the Social Security Amendments of 1972, Public Law 92-603, the Council's authority to review regulations and recommend changes was specifically deleted, and its role limited to advice on matters of "general policy." At that same time its purview was extended to include the Medicaid program. However, HIBAC has not

been called upon to advise the Secretary since late in 1976, and there are currently no members.

Effective Date

Enactment.

31. Confidentiality of Accreditation Surveys (sec. 938 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Current law contains certain disclosure safeguards relating to survey information used by the Secretary in connection with the hospital certification process under Medicare. However, the law only specifically refers to surveys conducted by the Joint Commission on the Accreditation of Hospitals (JCAH).

Explanation of Provision

The provision extends the same disclosure protections given JCAH survey information to similar survey information provided to the Secretary by the American Osteopathic Association or other national accreditation organizations.

Effective Date

Enactment.

32. Flexible Sanctions for Noncompliance With Requirements for End Stage Renal Disease (ESRD) Facilities (sec. 939 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Current law and regulations provide for decertification of end-stage renal disease (ESRD) facilities that are not in complete compliance with Medicare program requirements.

Explanation of Provision

The provision allows the Secretary to apply intermediate sanctions, such as a graduated reduction of reimbursement, to ESRD facilities whose noncompliance does not jeopardize patient health or safety or justify decertification of such facilities. Noncompliance would, in these cases, deal primarily with administrative requirements. This provision makes the treatment of ESRD facilities comparable to the treatment of nursing homes which are out of compliance.

The Committee intends that the Secretary, in applying the sanctions, should take certain factors into account. When reviewing a facility's compliance with the nurse staffing requirements, consideration should be given to the economic situation of areas with exceedingly high unemployment rates. For example, an area may be unable to recruit nurses because of the difficulty in finding employment for the nurses' spouses. In addition, in the event that a free

standing facility functions as a sole community provider for dialysis services, care shall be taken to ensure that Medicare beneficiaries requiring inpatient services continue to have those services available in a reasonably accessible facility.

Effective Date

Enactment.

33. Use of Additional Accrediting Organizations Under Medicare (sec. 940 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under current law, the Secretary has authority to rely on certain accrediting organizations in determining whether hospitals, skilled nursing facilities, home health agencies, ambulatory surgical centers and hospice programs meet Medicare requirements.

Explanation of Provision

The provision extends the Secretary's authority to permit reliance on such organizations in determining whether rural health clinics, laboratories, clinics, rehabilitation agencies, including outpatient rehabilitation facilities, and public health agencies meet Medicare requirements (and clarifies the Secretary's authority with respect to ambulatory surgical centers). The standards of an accrediting organization chosen must be at least equivalent to those of the Secretary, and it must have a satisfactory record of application of such standards.

Effective Date

Enactment.

34. Repeal of Exclusion of For-Profit Organizations From Research and Demonstration Grants (sec. 941 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Current law limits the awarding of grants (under sections 1110 of the Social Security Act and section 222(b) of the 1972 Medicare amendments) for the conduct of research and demonstrations to non-profit organizations. However, contracts are permitted to be awarded to both for-profit and non-profit organizations.

Explanation of Provision

The provision extends the research and demonstration grant authority to for-profit organizations.

Effective Date

Enactment.

35. Requirements for Medical Review and Independent Professional Review Under Medicaid (sec. 942 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under current law, medical review requirements for skilled nursing facilities (SNFs) and independent professional review for intermediate care facilities (ICFs) under Medicaid both call for teams of physicians, registered nurses and other appropriate personnel to conduct virtually similar kinds of review.

Explanation of Provision

The provision makes the State plan requirements for medical review consistent with the requirements for independent professional review thereby clarifying that there is no substantial statutory difference between review of SNFs and ICFs. The provision also corrects a technical error in present law to assure that Christian Science sanatoria are excluded from the revised medical review/independent professional review requirements.

Effective Date

Enactment.

36. Flexibility in Setting Rates for Hospitals Furnishing Long-Term Care Services Under Medicaid (sec. 943 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Current law contains special requirements for the establishment of payment rates for hospitals furnishing skilled nursing or intermediate care facility services under Medicaid.

Explanation of Provision

The provision deletes the requirements for setting payment rates for certain hospital-furnished long-term care. Under the provision such rates need only meet the general criteria applicable to rates for similar services provided by long-term care institutions to Medicaid recipients.

Effective Date

Enactment.

37. Authority of the Secretary To Issue and Enforce Subpoenas Under Medicaid (sec. 944 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Current law authorizes the Secretary to issue and seek enforcement of subpoenas under Medicare to obtain information needed in

connection with hearings, investigations and other matters related to program fraud and abuse.

Explanation of Provision

The provision authorizes the Secretary to issue and seek enforcement of subpoenas under Medicaid to the same extent that he has authority under the Medicare program.

Effective Date

Enactment.

38. Repeal of Authority for Payments To Promote Closing and Conversion of Underutilized Hospital Facilities (sec. 945 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Section 2101 of the "Omnibus Budget Reconciliation Act of 1981" (Public Law 97-35) authorized the Secretary to make Medicare and Medicaid payments to cover capital and increased operating costs associated with the conversion or closing of underutilized hospital facilities. The provision, which has never been implemented, restricts the number of facilities which may receive these funds to no more than 50 prior to January 1, 1984.

Explanation of Provision

The provision repeals this section of current law.

Effective Date

Enactment.

39. Presidential Appointment of and Pay Level for the Administrator of the Health Care Financing Administration (sec. 946 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

By law, the Administrator of the Health Care Financing Administration (HCFA) is in the Senior Executive Service and is appointed by the Secretary of Health and Human Services.

Explanation of Provision

The provision provides for the appointment of the Administrator of HCFA by the President, with the advice and consent of the Senate. The position and pay of the Administrator is increased to Level IV of the Executive Schedule.

Effective Date

Applies to appointments to the position made after enactment.

40. Exclusion of Certain Entities Owned or Controlled by Individuals Convicted of Medicare- or Medicaid-Related Crimes (sec. 947 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Current law authorizes the Secretary to bar from participation in Medicare (and to direct State agencies to bar from Medicaid) institutional providers in which a significant interest is held by a person convicted of program-related criminal offenses.

Explanation of Provision

The provision extends the Secretary's authority to also exclude from Medicare participation (and to direct State agencies to exclude from Medicaid participation) any entity or supplier of services in which a significant ownership or controlling interest is held by a person convicted of program related criminal offenses.

Effective Date

Enactment.

41. Judicial Review of Provider Reimbursement Review Board Decisions (sec. 948 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

The "Social Security Amendments of 1983" (Public Law 98-21) permits groups of providers to bring action in the judicial district in which the largest number of them are located. Under prior law, group judicial appeals could only be made in the District Court for the District of Columbia. Public Law 98-21 also requires certain appeals by providers which are under common ownership or control to be made as a group.

These provisions were included in a section of Public Law 98-21 entitled "Conforming Amendments" and were not assigned a specific effective date. Therefore, these provisions together with most of the prospective payment provisions were given the following effective date, "apply to items and services furnished by . . . a hospital beginning with its first cost reporting period that begins on or after October 1, 1983."

Explanation of Provision

The provision clarifies the effective date of the judicial review provisions.

Effective Date

Applies to court actions brought on and after the enactment of Public Law 98-21.

42. Access to Home Health Services (sec. 949 of the bill)

(Contained in S. 2062 as originally reported)

(a) Present Law

Current law requires a physician to certify to a patient's health needs and establish a plan of care before the patient can qualify for home health benefits. The Secretary is directed, however, to prescribe regulations to disqualify a physician from carrying out these functions for patients of any agency in which the physician has a significant ownership interest or a significant financial or contractual relationship.

Explanation of Provision

The provision permits a physician who has a financial interest in an agency which is a sole community provider to carry out the certification and plan-of-care functions for patients who will receive services from the agency. Existing regulations, which were intended to prevent potential conflicts of interest, have created a serious problem for the relatively few patients whose physicians have an interest in the only agency in the area. These patients have been unable to qualify for home health benefits unless they switched physicians.

Effective Date

Enactment.

(b) Present Law

Current regulations specifying which physicians are disqualified from carrying out the certification and plan-of-care functions for the patients of a home health agency include physicians who are uncompensated officers or directors of agencies even though they have no financial interest in its operation.

Explanation of Provision

The provision deletes from the list of disqualified physicians uncompensated officers or directors of agencies. These physicians do not stand to gain or lose from referrals to the agency.

Effective Date

Enactment.

43. Provider Representation In Peer Review Organizations (PROs) (sec. 950 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under current law, no health care facility such as a hospital may be a peer review organization although they may perform "delegated review" for a peer review organization. The law specifically pro-

hibits the Secretary of HHS from contracting with an entity which is, or is affiliated with (through management, ownership or common control), a health care facility. The Secretary, by regulation, has interpreted this to mean that a peer review organization (PRO) may not have a governing body which has as a member any individual who is a governing body member, officer, or managing employee of a health care facility.

It is common among professional standards review organizations (PSRO's), which are being phased out and replaced by PRO's, for one or two hospital administrators to sit on the PSRO board. The regulation could have the effect of prohibiting any physician or other person who is on the board of, or has certain administrative responsibilities in, a hospital from serving on the board of a PRO.

Explanation of Provision

The provision provides for limited representation of provider related individuals on PRO's. In the case of a PRO with a governing body of 15 or fewer members, one such member may be a governing body member, officer, or managing employee of a health care facility; and in the case of a PRO with a governing body of more than 15 members, no more than two such members may be a governing body member, officer, or managing employee of a health care facility.

Effective Date

Enactment.

44. Prospective Payment Assessment Commission (sec. 951 of the bill)

Present Law

The "Social Security Amendments of 1983" (P.L 98-21) provided for the implementation of a prospective payment system for hospitals under the Medicare program. The legislation established an independent, legislative-branch commission to assist the Department of Health and Human Services (HHS) and the Congress in dealing with the issues that will arise with respect to the new payment method. This Prospective Payment Assessment Commission is required to make recommendations concerning the annual percentage increase factor for diagnosis related group (DRG) payment rates. The Commission is also required to make recommendations with respect to changes in the DRGs based on its evaluation of scientific evidence.

Explanation of Provision

The provision would make several clarifying changes. It would clarify that the Commission is an independent authority and responsible for requesting appropriations. The Commission would be exempt from competitive public bidding (considered to be too cumbersome for an organization of the Commission's size) and from open-meeting requirements. Further, HHS would be directed to provide the Commission with basic support services and be reimbursed out of funds of the Commission. The provision would also authorize HHS to finance clinical trials under certain conditions. Provision would also be made for the appointment of an executive director. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission similar to those provided to physicians employed in the Executive Branch.

Effective Date

Enactment.

45. Medicaid Clinic Administration (sec. 952 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

By law, States may cover clinic services under their Medicaid programs. To assure that the clinic services are provided on a safe and appropriate basis, regulations issued by the Department of Health and Human Services limit coverage to situations where services are furnished under the direction of a physician. In certain cases, the physician direction rule has been interpreted as requiring that clinic administrators be physicians.

Explanation of Provision

The provision would direct the Department of Health and Human Services to modify the physician-direction requirement to clarify that the administrator of a clinic need not be a physician.

Effective Date

Enactment.

46. Enrollment and Premium Penalty With Respect to Working Aged Provision (sec. 953 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

The "Tax Equity and Fiscal Responsibility Act" (TEFRA) required employers to offer their employees aged 65 to 69 the same health benefits plan as offered to their younger workers. At the employee's option, Medicare payments may be secondary with respect to himself and to a spouse if age 65-69. Aged employees and spouses who elect enrollment in such employer offered health benefit plans may wish to delay enrollment in Part B because Part B coverage may be duplicative. However, these persons are currently subject to a late enrollment penalty. By law, the monthly Part B premium is increased by 10 percent for each full 12 months that individuals delays enrollment in the program beyond their initial enrollment period.

Explanation of Provision

The provision would waive the Part B delayed enrollment penalty for workers and their spouses aged 65 to 70 who elect private coverage under the provisions of TEFRA and would establish special enrollment periods for such workers. The waiver would apply for the period during which an individual continued to be covered under an employer's group health benefits plan.

Effective Date

Enactment.

47. Emergency Room Services (sec. 954 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

The "Omnibus Budget Reconciliation Act of 1981" (P.L. 97-35) included a provision requiring the Secretary of HHS to place reasonable limits on hospital costs and physician charges for outpatient services. The limits were to be reasonably related to the charges for similar services in physician's offices in the area. The statute specifically exempted from the outpatient limits "bona fide emergency services provided in an emergency room."

The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) included a provision to eliminate duplicate overhead payments for outpatient services. The provision added authority for the Secretary to reduce the payment to a physician providing services in an outpatient department by a factor representing the overhead costs already being paid by Medicare through the payment to the hospital.

The Secretary of HHS issued implementing regulations for these provisions on October 1, 1982. The definition of "bona fide emergency services" was limited to services necessary to prevent death or serious impairment. After receiving public comment, the Department of HHS reconsidered the definition. Although the regulations have not yet been reissued, it appears that the Department is prepared to broaden the definition.

Explanation of Provision

The provision would provide for the following statutory definition of "bona fide emergency services":

> Services provided in a hospital emergency room after the sudden onset of a medical condition manifesting itself by symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

The Committee believes that a statutory definition of "bona fide emergency services" is necessary to express clearly the intent of Congress in this regard.

Effective Date

Services furnished on or after enactment.

48. Nurse Anesthetists (sec. 955 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under the new prospective payment system enacted as a part of the Social Security Amendments of 1983 (P.L. 98-21), Medicare's payments to hospitals under Part A will be based on the diagnosis of the patient. Each diagnosis-related group (DRG) payment is intended to cover all the services that hospitals customarily furnish in caring for patients with a specified diagnosis.

Certified registered nurse anesthetists (CRNAs) have a variety of employment arrangements. Nearly 40 percent of all anesthesia services are provided by CRNAs employed by, or under contract with, hospitals. Certified registered nurse anesthetists who are paid by the hospital often assist at operations by anesthetising the patient. A part of each hospital's DRG payment is intended to cover these costs. On the other hand, a physician might provide the anesthetic, and in these cases the physician can bill Medicare separately. Physicians may also employ nurse anesthetists and bill for their services through part B. Since a hospital will be paid the same amount regardless of whether it pays a CRNA to perform the procedure, or a physician or a CRNA whom he employs, gives the anesthetic at no cost to the hospital, there is a clear financial incentive for hospitals to have physicians replace CRNAs employed by the hospital.

Explanation of Provision

The provision provides that the costs a hospital actually incurs in employing CRNAs are to be reimbursed on a reasonable cost basis. Thus, the hospital will have neither a financial incentive or disincentive to employ CRNSs. The costs may not be based on a greater number of CRNAs than were employed by a hospital in 1982, unless the Secretary determines that patient volume, patient mix, or a loss of physicians' services requires otherwise.

The provision further requires the Secretary to conduct a study and report to Congress on an alternative method for reimbursing for these services. Such alternative method should not discourage the use of CRNAs.

Effective Date

Hospital reporting periods beginning on and after October 1, 1984.

49. Prospective Payment Wage Index (sec. 956 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

The "Social Security Amendments of 1983" (P.L. 98-21) provided for the implementation of a prospective payment system for hospitals under the Medicare program. Under the system, payments made to hospitals are adjusted to reflect differences in hospital area wage levels. The wage index is calculated based on wage and employment data maintained by the Bureau of Labor Statistics (BLS) of the Department of Labor. This data is currently the most reliable national data available. However, it is an inadequate measure of wage differences because it fails to accurately reflect the relative use of part time and full time employees in calculating the index.

Explanation of Provision

The provision would direct the Secretary of Health and Human Services to consult with the Secretary of Labor to develop methods of refining and improving the adequacy and equity of the hospital wage index, taking into account wage differences of part time and full time workers. The Secretary of HHS would be required to report to the Congress by May 1, 1984.

The provision would further require the Secretary to adjust, if found appropriate, a hospital's payment to reflect changes made in the index. Such adjustments would be made for reporting periods beginning on or after October 1, 1983. In making any necessary adjustment for the first reporting period beginning on or after October 1, 1984, any overpayment or underpayment that may have occurred in the previous cost reporting period would be taken into account.

Effective Date

Enactment

50. Hospice Contracting for Core Services (sec. 957 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Public Law 98-248, the "Tax Equity and Fiscal Responsibility Act of 1982", authorized for the period November 1, 1983 to October 1, 1986 Medicare Part A coverage for hospice services provided to terminally ill Medicare beneficiaries with a life expectancy of six months or less. The law specifies that a hospice must routinely provide directly, substantially all of the following "core services": nursing care, medical social services, physician's services, and counseling services. The remaining "non-core services" may be provided either directly by the hospice or under arrangements with others, in which case the hospice must maintain professional management responsibility for all such services furnished to an individual, regardless of the location or facility in which such services are furnished.

Under existing regulations, a hospice may use contracted staff to meet the "core service" needs of its patients but only when necessary to supplement hospice employees during periods of peak patient loads or under extraordinary circumstances.

Explanation of Provision

The provision would permit the Secretary to waive the nursing care "core services" requirements for hospices that are located in rural areas, that were in operation on or before January 1, 1983, and that have demonstrated a good faith effort to hire their own nurses. A waiver request would be granted automatically unless expressly denied by the Secretary within 60 days. The granting of a waiver would not preclude the favorable consideration of a subsequent waiver request should such a request be made.

In providing for this waiver, the Committee emphasizes that it does not support or condone the establishment of hospices which serve only as brokers for services. Hospices which receive core-service waivers would be expected to exert professional management responsibility over the services and would be accountable for assuring that they are rendered consistent with the plan of care.

The provision would also require the Secretary to study the necessity and appropriateness of the core service requirement and report his findings to Congress within 18 months of enactment. The Committee wishes to express its interest in having the Secretary make recommendations for (1) legislative action to further protect hospice patients and the Medicare program from fraud and abuse and (2) standards of quality to be used in connection with hospice services.

Effective Date

Enactment.

51. Exemption of Public Psychiatric Hospitals From Provision Limiting Reimbursement to SNF Rates (sec. 958 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under the terms of a reimbursement experimentation contract with the State of New Jersey, Medicaid patients who need skilled nursing or intermediate care facility care, but who are waiting in a hospital for placement in a nursing home, are subject to different reimbursement rules than those who need acute inpatient hospital services. If the Secretary determines that the hospital has no excess beds, and if there are no excess hospital beds in the hospital's service area, the reimbursement for patients awaiting nursing home placement is set at the hospital's acute care rate; otherwise, Medicaid reimbursement must reflect the level of care actually received by the patient. (A similar Medicare statutory provision which would make this policy applicable nationwide has not yet been implemented.)

The application of this policy to public psychiatric hospitals in New Jersey has created a problem for the State and some of its localities. After July 1, 1984, reimbursement for Medicaid patients in these facilities awaiting nursing home placement will no longer be set at the acute care rate, but will be lowered to the skilled nursing facility rate. This will result in a sudden drop in the Medicaid reimbursement rate to the affected facilities by as much as 50 percent.

Explanation of Provision

The provision delays until July 1, 1985, the application of any reimbursement reductions required to be made to public psychiatric hospitals due to the level of care received by Medicaid patients in such hospital. The provision further requires that one-third of the reductions take effect during the year ending June 30, 1986, and that the remaining two-thirds of the reductions take effect during the year ending June 30, 1987.

The Committee believes that a gradual phase-in of the policy under the New Jersey reimbursement experiment would be appropriate.

Estimated Cost

	Millions
Fiscal year:	
1984	$5
1985	10
1986	6
1987	3
4-year total	$24

Effective Date

Enactment.

52. Certification of Psychiatric Hospitals (sec. 959 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under present law, psychiatric hospitals must be accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) in order to participate in Medicare and Medicaid. Psychiatric units of general hospitals must also be accredited by the JCAH in order to receive Medicaid payments for the care of children.

Explanation of Provision

The provision permits psychiatric hospitals and psychiatric units of general hospitals to participate in Medicare and Medicaid on the basis of a survey by the Secretary of Health and Human Services or, if found appropriate, accreditation by the American Osteopathic Association or the JCAH.

Effective Date

Enactment.

53. Payments to Teaching Physicians (sec. 960 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under a provision of current law, which has not yet been implemented, teaching physicians who practice primarily in teaching hospitals may be paid charges for their services to Medicare patients if charges for their services are also billed to other patients. The level of charges that is to be paid by Medicare under present law is to be based on the amounts charged and collected for non-Medicare patients.

Implementation of this policy could result in large payment reductions, and financial problems, for some teaching hospitals in States which have very low Medicaid payment rates. These rates sometimes represent as little as 25 percent of the area's prevailing charges. Their use in calculating Medicare payment levels would reduce Medicare reimbursement substantially.

Explanation of Provision

The provision provides that the Medicare reasonable charge for a physician's service furnished in a teaching hospital may not be less than 75 percent of the prevailing charge for that service in the locality.

Effective Date

Enactment.

54. Pacemaker Reimbursement Review and Reform (sec. 961 of the bill)

Present Law

Current law provides for the physician services associated with the implantation of cardiac pacemakers and post-implantation monitoring of these devices to be reimbursed under Part B. A number of criticisms have been raised concerning current Medicare policies and practices relating to cardiac pacemakers. The criticisms focus on the frequency of trans-telephonic monitoring of pacemakers and physician fees for the implantation of pacemakers.

S. 2062

The bill would have required the Secretary of Health and Human Services to issue revisions by February 1, 1984 to the current coverage guidelines on the frequency of trans-telephonic monitoring procedures considered to be reasonable and necessary. The Secretary is now reviewing Medicare policies in this area. As a part of this review, the American College of Cardiology, the American Heart Association, the American Medical Association, and other organizations and individuals with expertise in this area will provide materials to the Department. It was anticipated that the February 1, 1984 date provided the Department the necessary time to complete its analysis and issue revised guidelines.

The provision would have required the Secretary to review and report to the Congress on the appropriateness of the current rate of physician reimbursement for services associated with implantation and replacement of pacemakers and pacemaker leads. In conducting this review, the Secretary was to take into account the amounts recognized as reasonable with respect to the procedures and the time and difficulty of the procedures compared to those charged when the rates were first established. The Committee thus intended that the Secretary take into consideration improvements in pacemaker implantation and reductions in the time required for such procedures that have occurred over the past decade.

The provision required the Secretary, through the Commissioner of the Food and Drug Administration (FDA), to provide for a manufacturer-based registry of all cardiac pacemaker devices and leads for which payments may be made under Medicare. The bill required manufacturers to maintain a registry on its devices and leads which includes: model identification, serial number, the name of the recipient, the date and geographic location of the implantation or removal, and the name of the physician, hospital or other provider. The registry would include any express or implied warranties associated with the device and any other information which the Secretary deemed appropriate. The registry would be readily accessible to duly authorized agents of the Food and Drug Administration.

The purpose of the registry was to assist the Secretary in determining when Medicare payments for a replacement pacemaker may properly be made, in determining when inspection by the FDA may be necessary for purposes of review and testing for malfunctions of pacemakers, in tracing the performance of cardiac pacemaker devices and leads, and in carrying out such other studies as the Secretary determined appropriate. The Secretary was specifically prohibited from identifying any recipient of a pacemaker by name.

The Secretary was authorized to require, by regulation, that all patients bearing a device or lead for which Medicare payment was made or requested, be registered with the manufacturer of the device or lead. The Secretary could, also, by regulation, require that any device or lead explanted from any such patient be returned to the manufacturer of same. Failure to return an explanted device or lead could be grounds for the intermediary to deny payment for the replacement of such device or lead.

The Secretary could require the manufacturers to maintain accurate records and report annually to the FDA on the results of all returned product analyses and on such other clinical experiences as are deemed appropriate. In the case of adverse performance, manufacturers would be required to provide prompt notification to the FDA.

The bill authorized the Secretary to require the manufacturer to test or analyze each returned cardiac pacemaker device or lead and provide the test results to the institution or party who returned it to the manufacturer together with information as to whether or not such unit qualifies for any warranty or other credit. In any case where the Secretary has reason to believe that replacement of a pacemaker is related to its malfunction, the Secretary could require that FDA personnel have access to the manufacturers testing records or may verify such testing.

Modified Proposal

This provision would modify the provision previously agreed to by the Committee as part of S. 2062, which directed the Secretary to study the impact technology should have on the costs of physician services, publish guidelines on the frequency and appropriate payment levels for trans-telephonic monitoring, and establish a manufacturer-administered pacemaker registry.

As a result of the modification (1) the Secretary would be required to publish the revisions of the current coverage guidelines by April 1, 1984, (2) the Secretary also would be required to study the reasonableness of Part A payments associated with pacemaker implants and (3) a pacemaker registry provided through the FDA, rather than manufacturer-based, would be required.

Effective Date

Enactment.

55. Open Enrollment Period for Health Maintenance Organizations and Competitive Medical Plans (sec. 962 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Under current law, health maintenance organizations (HMOs) and competitive medical plans (CMPs) are required to have an open enrollment period of at least 30 days during which time they must accept Medicare beneficiaries up to the limits of their capacity.

Explanation of Provision

The provision requires the Secretary to designate one 30-day period in which all of the CMPs and HMOs in an area participating in Medicare must conduct open enrollment. The CMP or HMO would be permitted, in addition, to provide for open enrollment at other times during the year or hold enrollment open throughout the year. The Secretary would be required to establish annual per capita rates in a manner that assures that the beneficiaries enrolling during the designated 30-day open enrollment period will not have their premiums increased or their benefits decreased for the 12-month enrollment period for which the beneficiary is enrolling.

The Secretary, in establishing the open enrollment period for a geographic area, would be directed to consult with the CMPs or HMOs in the area concerning the timing of the annual 30-day open enrollment period. It is the intent of the Committee that the majority of CMPs or HMOs annual enrollments occur during the coordinated open enrollment period.

The Committee understands that there may be some difficulty in administering this provision and has therefore allowed the Secretary a period of not more than three years to phase in this provi-

sion. The Committee intends that the Secretary make every effort to designate open enrollment periods for different areas as soon as possible and not wait until the second or third year of this period before designating open enrollment periods.

Effective Date

Enactment.

56. Waivers for Social Health Maintenance Organizations (sec. 963 of the bill)

Present Law

Present law gives the Secretary general authority to conduct experiments and demonstrations. While the Department has provided start-up funding for four demonstration projects for social HMO's, operational funding has not been provided.

Explanation of Provision

The amendment requires the Secretary to approve certain waivers for a project to demonstrate the concept of a social HMO at four sites within 30 days after submission of a waiver request or within 30 days of enactment, whichever date is earlier.

Effective Date

Enactment.

57. Funding for PSRO Review (sec. 964 of the bill)

Present Law

Since 1982, the PSRO program has been hampered by inadequate and uncertain funding. In order to avoid these problems in the future, legislation was enacted earlier this year (P.L. 98-21) which provides that the soon-to-be-established PRO's to be automatically funded outside the appropriations process.

Under this 1983 legislation, the Secretary of Health and Human Services is directed to pay PRO's amounts determined to be reasonable, but not less than the 1982 funding levels (adjusted for inflation).

Because it was believed that the PRO program would replace PSRO's early in fiscal year 1984, this special authorization was not extended to the expiring PSRO's. However, delays in issuing regulations for the new PRO program have made it necessary to continue funding PSRO's well into fiscal year 1984.

It now appears likely that the PSRO appropriation will not be sufficient to cover the costs of their protracted 1984 operations.

Explanation of Provision

The provision would permit funding of PSRO's out of the part A Trust Fund, making funding no longer subject to the appropriations process. In addition, two dates contained in the PRO legislation would be moved back three months to take into account the delay in implementation.

The date by which hospitals are required to have an agreement with a PRO would be changed from October 1, 1984, to January 1, 1985. The date on which Medicare claims processing organizations can first qualify as PRO's would be similarly changed.

Effective Date

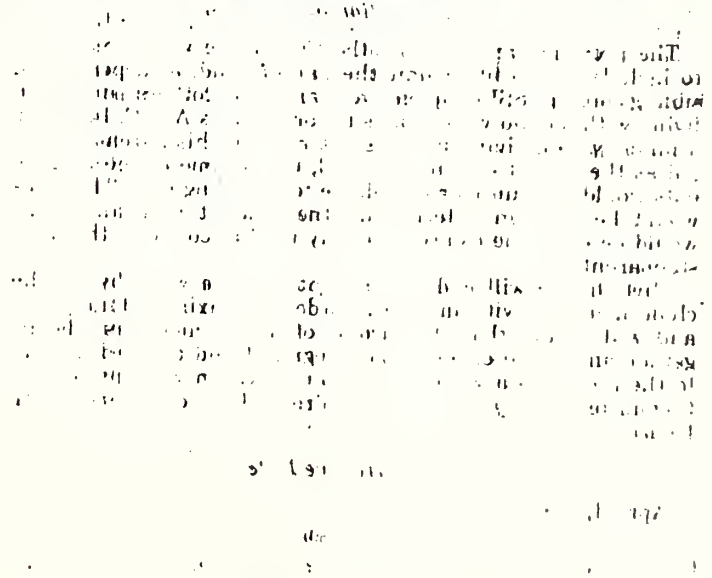
May 1, 1984.

58. Other Considerations

Under a provision of the 1980 amendments, small rural hospitals are allowed to temporarily participate in Medicare under certain circumstances even though they are unable to meet the Medicare requirement that they provide 24-hour nursing. One of the conditions is that the hospital's lack of nursing must be due to a temporary nurse shortage and that the hospital is making a good faith effort to comply with the program's nursing standards.

The Committee believes that in assessing the hospital's effort to attract personnel, consideration should be given to the economic conditions in the area in which the hospital is located and the communities ability to attract and pay skilled hospital staff and provide employment for a spouse. Specifically, factors such as rate of unemployment, relative poverty and hardship resulting from natural disasters or economic dislocation should be identified and given weight.

In the case of a facility which functions as a sole community provider, or where a hospital is located in a geographically remote area, care shall be taken to ensure that hospital emergency services continue to be accessible to area residents.



B. Income Maintenance Provisions

Aid to Families With Dependent Children (AFDC) Provisions

1. Parents and Siblings of Dependent Child Included in AFDC Family (sec. 971 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

There is no requirement in present law that parents and all siblings be included in the AFDC filing unit. Families applying for assistance may exclude from the filing unit certain family members who have income which might reduce the family benefit. For example, a family might choose to exclude a child who is receiving social security or child support payments, if the payments would reduce the family's benefits by an amount greater than the amount payable on behalf of the child. In addition, a mother who is a minor is excluded if she is supported by her parents. However, if she has no income of her own which may be attributed to her child, the child may qualify for assistance as a one-person unit, and receive proportionately more in assistance than it would receive as part of a two-person unit. The income of the parents of the minor parent is not considered in determining the eligibility of the child.

Explanation of Provision

The provision approved by the Committee would require States to include in the filing unit the parents and all dependent minor siblings (except SSI recipients and any stepbrothers and stepsisters) living with a child who applies for or receives AFDC. In addition, if a minor who is living in the same home as his parents applies for aid as the parent of a needy child, the income of the minor's parents would be counted as available to the filing unit. The rules that would be used in determining the amount of available income would be the same as are currently used in counting the income of stepparents.

This change will end the present practice whereby families exclude members with income in order to maximize family benefits, and will ensure that the income of family members who live together and share expenses is recognized and counted as available to the family as a whole. A similar provision was approved by the Committee last year, but was dropped in conference with the House.

Effective Date

April 1, 1984.

Estimated Savings

Fiscal year:	Millions
1984	$35
1985	135
1986	140
1987	145
4-year total	$455

2. Households Headed by Minor Parents (sec. 972 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

A minor parent who has a child, and who leaves home, may establish her own household and claim AFDC as a separate family unit. The income of the parents of the minor parent is not automatically counted as available to the minor parent, because they are not sharing the household.

Explanation of Provision

In the case of a minor parent who is not and has never been married, AFDC may be provided only if the minor parent resides with her parent or legal guardian, unless the State agency determines that (1) the minor parent has no parent or legal guardian who is living and whose whereabouts are known, (2) the health and safety of the minor parent or the dependent child would be seriously jeopardized if she lived in the same residence with the parent or legal guardian, or (3) the minor parent has lived apart from the parent or legal guardian for a period of at least one year prior to the birth of the child, or before claiming aid, whichever is later. The State agency would be given authority to make payments to a protective payee with respect to a minor parent affected by the provision, until the individual is no longer considered a minor by the State.

The Committee approved a similar provision last year, but it was dropped in conference with the House.

Effective Date

April 1, 1984.

Estimated Savings

Fiscal year:	Millions
1984	$5
1985	20
1986	20
1987	20
4-year total	$65

3. Clarification of Earned Income Provisions (sec. 973 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

The AFDC statute was amended in 1981 to change the way in which earned income is counted for purposes of determining eligibility and benefit amounts. As amended by Public Law 97-35, the law currently requires the States to disregard the following amounts of a family's earned income—

Eligibility Determination: (1) the first $75 of monthly earnings for full time employment; and (2) the cost of care for a child or incapacitated adult, up to $160 per child per month.

Benefit Calculation: (1) the first $75 of monthly earnings for full time employment; (2) child care costs up to $160 per child per month; and (3) $30 plus one-third of earnings not previously disregarded.

The $30 plus one-third disregard is allowed only during the first 4 consecutive months in which a recipient has earnings in excess of the standard work expense and child care disregards.

Courts in several States have been asked to interpret whether the term "earned income" refers to the gross amount earned by an individual before deductons are taken (for income taxes, insurance, FICA, support payments, or other items, regardless of whether the deduction is voluntary or involuntary), or whether the term refers to net income, after such deductions are taken. Regulations issued by the Department of Health and Human Services require that the term be interpreted as referring to gross income. However, courts in two States have ruled that the term must be interpreted as referring to net income.

Explanation of Provision

The statute would be amended to make clear that the term "earned income" means the gross amount of earnings, prior to the taking of payroll or other deductions. The provisions in the AFDC statute which require that specified amounts of earned income be disregarded in determining eligibility and benefits have historically been interpreted as requiring that such amounts be deducted from gross, rather than net, earnings.

The Committee agrees with the Department that there was no intention to change this interpretation when it approved the 1981 AFDC amendments. The Committee notes that when the Congressional Budget Office estimated the savings expected to be derived from the changes in 1981, it followed the interpretation shared by the Department and the Committee that the proposed disregards would apply to gross earnings.

Effective Date

Enactment.

Estimated Savings

Fiscal year:	Millions
1984	$8
1985	24
1986	24
1987	24
4-year total	$80

4. CWEP Work for Federal Agencies Permitted (sec. 974 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

The Omnibus Budget Reconciliation Act of 1981 authorized States to conduct community work experience programs "which serve a useful purpose." Employable recipients may be required to participate in these programs as a condition of eligibility for AFDC.

Explanation of Provision

The statute would be amended to make clear that the participation in a CWEP program may include work performed for a Federal office or agency. Such work would not be considered to constitute Federal employment, and the State agency would be required to provide appropriate workers' compensation and tort claims protection to each participant.

Effective Date

Enactment.

Estimated Savings

No budget effect.

5. Earned Income of Full-Time Students (sec. 975 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

The statute provides that eligibility for AFDC benefits is limited to families with gross incomes (income before application of any disregards) at or below 150 percent of the State's standard of need. A provision was included in Public Law 97-377, the Job Training Partnership Act, which amended the gross income limitation to allow States to disregard the income of an AFDC youth which is derived from a program carried out under that Act, in such amounts and for such period of time (not to exceed six months with respect to earned income) as the Secretary of Health and Human Services may provide in regulations.

Explanation of Provision

Under the Committee provision, for purposes of applying the gross income limitation, States would also be allowed to disregard

the income of an AFDC child who is a full-time student, under the same limitations with respect to amounts and periods of time as are applied in the case of youths who participate in a program under the Job Training Partnership Act.

Effective Date

Enactment.

Estimated Costs

Negligible.

Supplemental Security Income (SSI) Provisions

1. Adjustments in SSI Benefits on Account of Retroactive Benefits Under Title II (sec. 976 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

Legislation was enacted in 1980 (P.L. 96–265) aimed at ensuring that an individual's entitlement under the Old-Age, Survivors, and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs would not result in windfall benefits. Under this legislation, OASDI benefits that are paid retroactively following the initial determination of eligibility, are reduced by the amount of any excess SSI benefits that are paid because the OASDI benefits have been received in a lump sum rather than in the months when regularly payable.

Explanation of Provision

The Committee provision would amend the present requirement to allow the adjustment of benefits in additional situations. First, in the case where retroactive OASDI benefits are paid before the SSI benefits, but for the same period, the retroactive SSI amount otherwise payable would be reduced by the amount that would not have been paid had OASDI been paid when regularly due. Second, the provision would allow for an adjustment of SSI and OASDI benefits which result from either an initial determination of eligibility or a resumption of payments following a period of suspension or termination of those benefits. In cases where retroactive OASDI benefits result from posteligibility events, such as earnings recomputations, the Secretary would be authorized to adjust those benefits when it is administratively feasible.

Finally, present law would be amended to coordinate the benefit adjustment provision with the SSI retrospective accounting system. Under present law, it is possible that the two-month lag in counting OASDI income for purposes of determining the SSI benefit amount can result in adjustment for less than the full retroactive period. The proposed change would make it possible to adjust benefits paid for the entire retroactive period.

Effective Date

Applicable to retroactive benefits (either OASDI or SSI) payable beginning 7 months after enactment.

Estimated Savings

Fiscal year:	Millions
1984	0
1985	$12
1986	17
1987	18
4-year total	$47

Child Support Enforcement (CSE) Provisions

Regulatory Initiative on Medical Support (sec. 977 of the bill)

(Contained in S. 2062 as originally reported)

Present Law

The Child Support Enforcement (CSE) program is a Federal-State partnership under which States are required to have a program which locates absent parents, establishes paternity and obtains and enforces support orders.

Explanation of Provisions

The provision would require the Secretary to issue regulations which would require State CSE agencies to petition the court to include medical support as part of the child support order whenever health care coverage is available to the absent parent at a reasonable cost. In addition, the regulation would provide for improved information exchange between the CSE and medicaid agencies on the availability of health insurance coverage.

Effective Date

Enactment.

C. Social Security Provisions

1. Special Social Security Treatment for Church Employees (sec. 981 of the bill, secs. 1402, and 3121 of the Code, and secs. 210 and 211 of the Social Security Act)

Present Law

FICA and self-employment taxes

The Federal Insurance Contributions Act (FICA) imposes separate taxes on employers and employees equal to a percentage of wages paid as remuneration for employment, subject to certain exceptions. The 1984 FICA tax rates are 7 percent each for employers and employees (a combined 14 percent rate); a credit against the employee FICA tax of 0.3 percent of 1984 wages is allowed. These rates are scheduled to increase in stages until reaching a maximum of 7.65 percent each for employers and employees (a combined 15.3 percent) in 1990. A ceiling ($37,800 in 1984), adjusted annually for increases in average wages, is imposed on the amount of wages subject to FICA taxes. Both the employee and employer taxes are paid to the Internal Revenue Service by the employer (in the case of employee taxes, after withholding these taxes from the employee's wages) and are deposited in the social security trust funds.

For self-employed individuals, a tax is imposed on self-employment income under the Self-Employment Contributions Act (SECA). This tax equals 14 percent of self-employment income in 1984 and is scheduled to increase to 15.3 percent by 1990, i.e., the rates are equal to the combined employer-employee FICA tax rates. However, for years through 1989, self-employed individuals are allowed a credit against the tax for a portion of self-employment income (2.7 percent in 1984). Thus, the net rate of SECA tax is somewhat lower than the combined FICA rate. Thereafter, self-employed individuals would be permitted special deductions designed to treat them in much the same manner as employees and employers are treated for social security and income tax purposes. The SECA tax does not apply to income which (together with wages) exceeds the FICA tax base; additionally, the tax does not apply if self-employment income for the taxable year is less than $400.

Present law treats certain classes of employees, including employees of foreign governments and international organizations, as self-employed for purposes of social security taxes.

Employees of religious organizations

Prior to the Social Security Amendments of 1983 (P.L. 98-21), employees of nonprofit religious, charitable, educational or other tax-exempt organizations of the type described in section 501(c)(3) of the Code were covered by social security only if the organization

waived (or was deemed to have waived) its exemption from social security taxation. Organizations for whom coverage had been in effect for at least 8 years were entitled to terminate coverage upon 2 years' advance notice to the Treasury Department.

The Social Security Amendments of 1983 extend mandatory social security coverage to employees of nonprofit organizations (including religious organizations), effective January 1, 1984. This coverage applies to employees of organizations which previously terminated coverage as well as to employees of organizations which had never been covered by social security. As under prior law, wages of an employee of a tax-exempt organization are excluded from social security for tax and benefit purposes if less than $100 is paid to the employee in a calendar year.

Ministers and certain members of religious orders.—Under present law, employees who are ministers of a church in the exercise of their ministry or members of religious orders (other than members subject to a vow of poverty) in the exercise of duties required by the order are treated as self-employed individuals for purposes of social security taxes. Such individuals who are conscientiously, or because of religious principles, opposed to participation in a public insurance system may elect to be exempt from self-employment taxes and credit under social security (on earnings for services as ministers or members of religious orders) by filing an irrevocable one-time application to that effect within two years of beginning their ministry. The treatment of ministers and members of religious orders not subject to a vow of poverty was not affected by the 1983 amendments.

Reasons for Change

The Committee remains committed to the policy of the 1983 amendments in extending mandatory social security coverage to employees of nonprofit organizations. Such employees are thereby assured protection under the old-age, disability, and hospital insurance programs of social security. In addition, the problem of windfalls accruing to workers with short periods of covered employment will be reduced. The Committee is aware, however, of the special problems which arise when a Federal tax (i.e., the employer's share of FICA taxes) is imposed directly upon a religious organization. Mandatory taxation of a religious organization inevitably raises concerns regarding the separation of church and state. Additionally, the taxation of amounts contributed to a church may suggest the possibility of government interference in the relationship of a church to its members.

The Committee bill attempts to resolve these concerns while maintaining mandatory social security coverage for employees of religious organizations and while continuing to provide equity between employees of religious organizations and other nonprofit organizations. Thus, the bill allows churches and certain church-controlled organizations to make a one-time election to treat their employees similarly to self-employed individuals for purposes of social security taxes. The election is limited to churches and organizations which state that they are opposed for religious reasons to the payment of social security taxes. If a church elects such treatment,

mental sources. However, where an organization satisfies both tests, the organization would not be eligible to make an election. The Committee specifically intends that church-run universities (other than religious seminaries) and hospitals which satisfy both tests will not be eligible to make an election. Auxiliary organizations of a church (including youth groups, women's auxiliaries, etc.) will generally satisfy neither of the Committee's tests and will thus be eligibile to make an election. Similarly, church pension boards or fund-raising organizations generally would qualify to make an election.

Information reporting requirement

An organization electing to exclude services for FICA purposes nonetheless continues to be required to furnish relevant information required of employers subject to income tax withholding (sec. 6051). This includes information with respect to the identity of employees and the amount of wages paid to each employee. The election will be permanently revoked by the Treasury if the organization fails to provide such information for a period of two years or more and, upon request by the Treasury Department, fails to furnish previously unfurnished information for the period covered by the election. The revocation will apply back to the first year of the two year period for which there was a failure to furnish such information.

Amount of remuneration subject to SECA taxes

The remuneration on which the employee of an electing institution is to be liable for SECA tax generally is to be the same as the amount which would have been subject to FICA tax if that individual had continued to be treated as an employee. Thus, business expenses are not to be subtracted in computing self-employment income (reimbursed business expenses are not to be included in self-employment income, however), the $400 threshold on self-employment-income does not apply, and a $100 threshold is to apply in determining whether this remuneration is subject to SECA tax. However, after 1989 these individuals will be eligible for a deduction, in computing SECA taxes, for the product of net earnings from self-employment and one-half of the SECA rate.

Refunds of taxes previously paid

Where a church or church-controlled organization makes an election with respect to FICA taxes, and the electing organization has paid FICA taxes for services performed after December 31, 1983, which are covered by the election, the Treasury is required to refund such taxes (without interest) to the electing organization. Such refund is to be conditioned upon the electing organization agreeing to pay to each present or former employee that portion of the refund which is attributable to the employee portion of FICA taxes collected by the organization from such employee. The employee will then not be entitled to any other refund for such taxes.

Estimated taxes

Employees of electing institutions generally will be required to make estimated tax payments with respect to their SECA liability.

However, the Committee intends that employees who become liable for SECA taxes for 1984 because of an election by their employer made before the first date, more than 90 days after the date of enactment on which a quarterly employment tax return is generally due, are to be relieved of estimated tax penalties with respect to quarters of 1984 prior to the date by which the election is required to be made.

Effective Date

This provision is effective for services performed after December 31, 1983.

Revenue Effect

This provision will reduce fiscal year receipts by $50 million in 1984, $12 million in 1985, $9 million in 1986, $5 million in 1987, $7 million in 1988, and $3 million in 1989.

2. Social Security Coverage for Legislative Branch Employees Not Covered by the Civil Service Retirement System (sec. 982 of the bill)

Present Law

The Social Security Amendments of 1983 (P.L. 98-21) extend social security coverage to newly hired legislative branch employees and to those legislative branch employees not already covered by the Civil Service Retirement System (CSRS) as of December 31, 1983. Current legislative branch employees who are exempt from social security coverage maintain that exemption even with a break in Federal service, provided the break is less than 365 days.

Due to a drafting oversight, legislative branch employees who, by participating in CSRS, established an exemption from social security on December 31, 1983, can subsequently elect out of CSRS and be covered by neither retirement system.

Explanation of Provision

The Committee provision would require legislative branch employees to be continuously covered by CSRS in order to retain the exemption from social security. Individuals electing to take a refund of CSRS contributions would thus become subject to social security on a mandatory basis since receipt of the refund necessitates a break in service and the termination (at least temporarily) of participation under CSRS. Individuals who leave employment in the legislative branch for any period less than 365 days would be covered by social security upon return to Federal employment only if they elected to receive a refund of CSRS contributions.

Effective Date

On enactment. Legislative branch employees exempt from social security but not still covered by CSRS on the date of enactment of this amendment would be permitted 30 days after the date of enactment in which to reenroll in CSRS.

Revenue Effect

This provision will have a negligible revenue effect.

3. Employees of Nonprofit Organizations Who Are Required to Participate in the Civil Service Retirement System (sec. 983 of the bill)

Present Law

The Social Security Amendments of 1983 (Public Law 98-21) extend social security coverage to employees of nonprofit organizations. Due to an oversight, employees in certain nonprofit organizations (Legal Service Corporations, for example) who are covered on a mandatory basis by the Civil Service Retirement System will thus be covered on a mandatory basis by social security as well. Because such employees are not actually Federal employees, they are not provided relief from double-taxation under Title II of the Federal Physicians Comparability Allowance Amendments of 1983 (Public Law 98-168), known as the Federal Employees' Retirement Contribution Temporary Adjustment Act.

Explanation of Provision

Under the Committee provision, employees of nonprofit organizations who are covered on a mandatory basis by CSRS would be treated like Federal employees for purposes of social security. They would therefore be covered by social security if newly hired after January 1, 1984, or if they had a break in Federal service lasting more than 865 days.

Effective Date

Effective with respect to service performed on or after January 1, 1984.

Revenue Effect

This provision will have a negligible revenue effect.

D. Grace Commission Provisions

1. Income and Eligibility Verification Procedures (sec. 991 of the bill)

Present Law

Wage data is used by the Social Security Administration and the Department of Agriculture for use in verifying eligibility for the AFDC, SSI and food stamp programs. The SSI program annually crosschecks data supplied by beneficiaries with the IRS/SSA data. State and local welfare agencies must request this data for use in verifying AFDC eligibility, unless quarterly wage data are available from their State unemployment compensation agencies; 42 jurisdictions collect wage data on a quarterly basis through their unemployment insurance (UI) programs, and three other States obtain this data through means other than the UI system.

Explanation of Provision

The provision would authorize and require the Internal Revenue Service and SSA to make available to Federal and State agencies data on earned and unearned income for use in administering means-tested Federal benefit programs. This data may be used only for the purpose of verifying eligibility for the programs. Agencies receiving data would be subject to the restrictions on unauthorized disclosure of confidential information that are currently applicable. The Committee anticipates that data would be provided to agencies by means of low-cost computer exchange of information.

The provision prescribes a new income verification system under title XI of the Social Security Act. Under this system: (1) all beneficiaries must provide social security numbers; (2) programs must obtain and utilize for verification purposes, earned and unearned income data provided to the Secretary of HHS by the IRS and SSA; (3) each State must maintain a system under which employers make quarterly wage reports to a State agency (the quarterly wage system may, but need not be, a part of the State's unemployment insurance system); (4) the State must use wage report information for purposes of verifying its eligibility requirements for any program.

The quarterly wage reporting requirement does not mandate a State to collect data through its unemployment insurance program, nor would any State be required to change its UI system to comply with the amendment. Further, no State now collecting quarterly wage information through the UI system, or by any other means, would be required to alter its existing wage reporting format or the extent of its coverage so long as an existing system is reasonably comprehensive.

States which do not have quarterly wage reporting systems would have the option of developing such systems either within their unemployment compensation programs or elsewhere in State government. If States use the unemployment program to operate the wage reporting system, its costs would be reimbursable as an unemployment administrative expense on the same basis and under the same conditions as now apply to those 40 States which currently use wage reporting for the unemployment program. (However, the amendment requires that other programs utilizing the data make appropriate payments for the costs involved in providing information. If a State elects to establish a wage reporting system in a manner which would not, under existing rules, qualify for reimbursement as an unemployment insurance program cost, the costs of the wage reporting system would be appropriately shared among all those programs required by the amendment to use the information it provides and among any other programs for which the State uses the system.

The provision also requires State agencies to adopt, to the extent possible, a standardized format and procedures for administering benefit programs to allow exchange of information between agencies authorized to receive this data for purposes of verifying eligibility. Procedures must be implemented to target the use of this information in those ways which are most likely to be productive in identifying and preventing ineligibility.

Effective Date

IRS is authorized to disclose unearned income data on the date of enactment, and is required to disclose such data as soon as is practicable to implement disclosure agreements including required safeguard reviews. The requirement to implement an income verification system under Title XI will be effective on April 1, 1985. However, the Secretary of HHS (Secretary of Labor, in the case of quarterly wage reporting) is authorized to grant a reasonable extension of time (in no event beyond October 1, 1986). Such extensions may be granted only when States adopt a good faith plan to achieve full implementation of the requirements no later than October 1, 1986.

Estimated Savings

Fiscal year:	*Millions*
1984	0
1985	−$31
1986	300
1987	391
4-year total	$660

2. Collection and Deposit of Payments to Executive Agencies (sec. 992 of the bill)

Present Law

The Department of Treasury has introduced the Treasury Federal Communications System (TFCS) and lockbox systems to provide for accelerated deposit of Federal receipts. (TFCS enables the Federal Government to effect immediate fund withdrawals by electronic transfer, while lockboxes permit faster bank deposit of Federal payments.) In fiscal year 1983, $94 billion in Federal receipts (both tax and nontax) were collected by TFCS, and another $1 billion through lockboxes. There remains, however, approximately $55 billion in annual nontax receipts that are collected by means other than accelerated deposit.

Explanation of Provision

Under this provision, the Secretary of the Treasury is authorized to prescribe the mechanisms that Federal agencies are to employ to collect revenues due the Government. Under the legislation, the Secretary is also authorized to prescribe the time frames within which funds collected by or for Federal agencies must be deposited for credit in the Treasury's account. In addition, the legislation generally reduces from 30 days to three days the statutory period for timely deposit of funds by custodians. Finally, the legislation confers the necessary enforcement authority. It is anticipated that the Bureau of Government Financial Operations will exercise the authority in this legislation as the Secretary's delegee.

It is expected that the Treasury will select from among six major collection mechanisms now available to it. These are automated paper processing techniques, electronic funds transfer under TFCS, preauthorized automatic withdrawals for recurring payments, corporate-to-corporate Automated Clearing House, Point-of-Sale, and home banking. However, as more efficient or effective mechanisms become available, the Treasury is authorized to require their use by agencies.

The regulations will require that agencies adopt collection and deposit methods prescribed by the Secretary. Agencies not complying with the regulations will be assessed a charge equal to the cost to the general fund of noncompliance, as determined by the Secretary. Any such charges will be deposited into a Treasury Cash Management Improvements Fund to be used for developing and implementing cash management initiatives.

Effective Date

The Secretary is required to issue regulations as soon as practicable, designed to achieve by October 1, 1986, full implementation of the accelerated deposit systems.

Estimated Savings

Fiscal year:	*Millions*
1984	0
1985	0
1986	$800
1987	800
4-year total	$1,600

3. Collection of Nontax Debts Owed to Federal Agencies (sec. 993 of the bill)

Present Law

Under section 6402, the Secretary may credit the amount of any overpayment of tax in one year (including any interest thereon) against any liability in respect of an internal revenue tax for the same taxpayer for another year. Overpayment of income taxes can be credited against any taxes due from the taxpayer, including stamp, excise or employment tax, and any interest, additional amount, addition to the tax or assessable penalty. When a debt to the United States has been reduced to judgment, or when a taxpayer is in bankruptcy, the IRS may offset the taxpayer's refund by the amount of the debt. There is, however, no clear authority to offset administratively refunds prior to when the taxpayer's obligation has not been adjudicated.

Beginning with tax returns filed in 1982, tax refunds due taxpayers who are delinquent in making child and spousal support payments must be applied against past-due support obligations if (1) the person designated to receive the support is receiving Aid to Families with Dependent Children from a State welfare agency and the State has received that person's assignment of the support obligation; (2) the State has made a reasonable effort to collect the support; (3) the amount of past-due support is at least $150; (4) the support has been delinquent for at least 3 months; and (5) none of the past-due support has been received by the IRS through the State agency's notification to the Department of Health and Human Services.

Explanation of Provision

The provision amends section 6402 to provide that the amount of any refund of internal revenue taxes would be reduced by the amount of any certified debt owed to the Federal government. The agency responsible for collecting the debt must certify to the Treasury that specific attempts to notify debtors have been made, as required in regulations to be issued by the Secretary, and that the debtor has not disputed the nature or the amount of the debt (or any dispute has been resolved by agreement between both the debtor and the agency), has not begun to repay the debt, and exhibits no reasonable intention to repay the debt. The agency must have entered into an agreement with the Secretary providing for the transmission of certified debt information to the Secretary before transmission occurs.

The Secretary is given the authority to prescribe the terms of agreements with other agencies. The Secretary will prescribe the format in which the information must be transmitted. In addition, the Secretary is authorized to test the offset procedures with selected programs at first, before fully implementing the program. The Secretary is authorized to disclose the amount of the refund being offset against the debt to the Federal agency for the purpose of, and only to the extent necessary in, administering this offset procedure. Disclosure would be required to be in the same manner and with the same safeguards as when disclosure is made to a State.

The Committee intends that AFDC child support obligations will be subject to offset before other Federal debts. The offset could not, however, be applied to beneficiary debts under the OASDI programs.

Effective Date

This provision would be effective for refunds to be paid after December 31, 1985 and before January 1, 1988. This is intended to provide an opportunity for the Congress to evaluate the program.

Estimated Savings

Fiscal year:	Millions
1984	0
1985	0
1986	$300
1987	500
4-year total	$800

E. Cover Over of Certain Federal Excise Taxes

1. Clarification of Definition of Articles Produced in Puerto Rico or the Virgin Islands (sec. 996 of the bill)

Present Law

Present law imposes a special excise tax on articles coming into the United States from Puerto Rico and the Virgin Islands. The tax is equal to the Federal excise tax that would be imposed if the articles had been manufactured or produced in the United States (sec. 7652). This tax is in lieu of the excise tax that would be imposed if the articles had been manufactured or produced in the United States or imported from another country.

Revenues collected from the tax on articles coming into the United States from Puerto Rico or the Virgin Islands are covered over (paid) to the treasury of the possession from which the article comes. No restrictions are imposed on the use of these revenues by Puerto Rico or the Virgin Islands.

The Government of Puerto Rico presently sponsors a redistillation program under which spirits originally distilled in the United States are transported to Puerto Rico and redistilled in that possession. Following redistillation, the spirits are returned to the United States for processing and marketing. As a result of their redistillation in Puerto Rico, the Puerto Rican Government receives a payment of $10.50 per proof gallon with respect to these redistilled spirits (i.e., the amount of Federal excise tax presently imposed on distilled spirits) because redistillation is considered to be Puerto Rican production.

Reasons for Change

The Committee is concerned that Federal excise tax revenues are being covered over to Puerto Rico when there is little or no economic nexus between the articles with respect to which payments are made and Puerto Rican input into the production of these articles. The Committee believes that payment of Federal revenues to Puerto Rico and the Virgin Islands should not continue with respect to articles not having a substantial economic nexus with those possessions. The redistillation program presently sponsored by Puerto Rico involves a process that likely would not occur without (1) the availability of Federal excise tax payments to Puerto Rico, and (2) the availability of subsidies by Puerto Rico to participants in the redistillation program.

The Committee also is concerned about cover over of Federal excise tax revenues with respect to cane neutral spirits because of subsidies provided to producers of those spirits by the Governments of Puerto Rico and the Virgin Islands. The Committee believes that permitting these cover overs to continue could result in adverse

competitive pressures on U.S. mainland distillers of neutral spirits who receive no similar subsidy.

At the present time, the Committee decided not to address the overall question of whether cover over of Federal excise tax revenues to Puerto Rico or the Virgin Islands is appropriate in any circumstances when those revenues are not similarly covered over to the States. Therefore, the Committee bill limits the payment of Federal excise tax payments with respect to articles containing distilled spirits to articles consisting of at least 92 percent rum.

Explanation of Provisions

The provision limits the cover over to Puerto Rico and the Virgin Islands with respect to articles containing distilled spirits to articles of which at least 92 percent of the alcoholic content is rum. The Committee understands that cover overs of excise taxes are determined under present law at the time an article enters the United States. The Committee further understands that this determination is not affected by any change in the character of the article after entry into the United States. Therefore, the full cover over will be available with respect to articles containing distilled spirits satisfying the 92-percent test upon entry into the United States even if these spirits are subsequently blended with other distilled spirits into an article not satisfying that requirement. However, if such blending occurred before entry into the United States, the cover over would be denied.

Effective Date

These provisions generally are effective with respect to articles coming into the United States from Puerto Rico or the Virgin Islands after February 28, 1984.

A transitional rule permits cover over to Puerto Rico of revenues from articles containing redistilled spirits and cane neutral spirits, which articles come into the United States after February 28, 1984 and before July 1, 1984. However, cover overs under this transitional rule are permitted only to the extent that the total payments with respect to such redistilled spirits and cane neutral spirits do not exceed the excess of $130 million over the total cover overs received with respect to these articles after June 30, 1983, and before February 29, 1984.

A second transitional rule provides that cover overs after February 28, 1984, and before July 1, 1984, with respect to redistilled spirits and cane neutral spirits will terminate immediately if the Government of Puerto Rico or the Virgin Islands provides any incentive payment to a United States producer (other than reimbursement for direct costs of transportation between the United States and Puerto Rico in the case of redistilled spirits). For purposes of the second transitional rule, an incentive payment means any payment directly made by the applicable possession's government or any payment made by a business located in Puerto Rico to a U.S. producer, which payment is directly or indirectly related to receipt by that business of a payment from the Government of Puerto Rico.

Estimated Savings

Fiscal year:	Millions
1984	
1985	$260
1986	276
1987	296
4-year total	$832

2. Limitation on Transfers of Certain Excise Tax Revenues to Puerto Rico and the Virgin Islands (sec. 997 of the bill and sec. 7652 of the Code)

Present Law

Present law imposes a special excise tax on articles coming into the United States from Puerto Rico and the Virgin Islands. The tax is equal to the Federal excise tax that would be imposed if the articles had been manufactured or produced in the United States (sec. 7652). This tax is in lieu of the excise tax that would be imposed if the articles had been manufactured or produced in the United States or imported from another country.

Revenues collected from the tax on articles coming into the United States from Puerto Rico or the Virgin Islands are covered over (paid) to the treasury of the possession from which the article comes. No restrictions are imposed on the use of these revenues by Puerto Rico or the Virgin Islands.

Reason for Change

The Committee is concerned with the effect of the provisions allowing transfer of Federal tax revenues to Puerto Rico and the Virgin Islands. At the present time, however, the Committee decided not to address the overall question of whether cover over of Federal excise tax revenues to Puerto Rico or the Virgin Islands is appropriate in any circumstances when those revenues are not similarly covered over to the States. The Committee does believe that this practice should not be expanded absent a thorough examination of the issue. Therefore, the bill limits those payments to $10.50 per proof gallon, the present rate of the Federal excise tax imposed on distilled spirits.

Explanation of Provision

The provision limits the maximum cover over with spirits to any otherwise qualifying article containing distilled spirits to $10.50 per proof gallon, the amount of the present Federal excise tax on distilled spirits.

Effective Date

This provision is effective with respect to distilled spirits coming into the United States from Puerto Rico or the Virgin Islands after December 31, 1984.

Estimated Savings

Fiscal year	Millions
1984	0
1985	$45
1986	57
1987	61
4-year total	$163

VI. COSTS OF CARRYING OUT THE COMMITTEE PROVISIONS AND VOTE OF THE COMMITTEE

Budget Effects

In compliance with paragraph 11(a) of Rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the budget effects of the Committee provisions.

The budget effects of the provisions are presented in the tables in Part IV.

Summary statements about budget revenues and outlays follow.

The revenue provisions of the committee bill involving statutory changes are estimated to increase net budget receipts by $2.5 billion in fiscal year 1984, $10.6 billion in fiscal year 1985, $16.0 billion in fiscal year 1986, and $18.9 billion in fiscal year 1987. Thus, the total net revenue raised during the fiscal years 1984 through 1987 equals $48.0 billion.

The changes to the earned income credit affect both revenues and outlays, both of which are included in the above revenue totals. As a result, these changes will reduce revenues by $3 million in 1985, $93 million in 1986, $85 million in 1987, $77 million in 1988, and $73 million in 1989, and increase outlays by $5 million in 1985, $129 million in 1986, $120 million in 1987, $110 million in 1988, and $100 million in 1989.

The statutory changes made in the outlay provisions in the bill will reduce fiscal year budget outlays by $0.1 billion in 1984, $2.8 billion in 1985, $5.3 billion in 1986, and $6.6 billion in 1987. During the period including fiscal years 1984 through 1987, outlays will be reduced by a total of $14.8 billion.

(See also statements submitted, in Part VII of this report, by the Congressional Budget Office regarding the revenue and spending provisions of the bill.)

Vote of the Committee

In compliance with paragraph 7(c) of Rule XXVI of the Standing Rules of the Senate, the following statement is made relative to the vote by the committee on the motion to approve the deficit reduction provisions. These provisions were approved by a record vote of 20 ayes and 0 noes.

VII. REGULATORY IMPACT AND OTHER MATTERS TO BE DISCUSSED UNDER SENATE RULES

Regulatory Impact

Pursuant to paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate, the committee makes the following statement concerning the regulatory impact that might be incurred in carrying out the Committee provisions.

Revenue Provisions

Numbers of individuals and businesses who would be regulated

The provisions involve new or expanded regulations with respect to the Internal Revenue Code that will facilitate compliance with the Federal income tax laws.

Economic impact of regulation on individuals, consumers and business

The provisions have no regulatory impact on substantive economic activities of individuals, consumers or businesses other than through the provisions that are intended to improve the administration of, and compliance with, Federal income tax laws.

Impact on personal privacy

The provisions generally do not relate to the personal privacy of individuals, but authority will be made available for disclosure of tax return information in order to reduce the error-rate in the payment of benefits under Federal means-tested programs.

Spending Reduction Provisions

Number of individuals and businesses who would be regulated

The provisions to a large extent reduce the current regulatory requirement placed on individuals and businesses.

Economic impact of regulation on individuals, consumers, and business

The provisions have no new substantial economic impact on individuals, consumers or businesses.

Impact on personal privacy

The provisions generally do not relate to the personal privacy of individuals, but authority will be made available for disclosure of tax return information in order to reduce the error-rate in the payment of benefits under Federal means-tested programs.

Revenue and Spending Reduction Provisions

Determination of the amount of paperwork

Any change in the amount of paperwork that taxpayers and other individuals may have to do is incidental to their compliance with the provisions in the Internal Revenue Code, the medicare and medicaid programs, or Aid to Families with Dependent Children program.

Other Matters

Consultation with Congressional Budget Office on budget estimates and new budget authority

In accordance with section 403 of the Budget Act, the commitee advises that the Director of the Congressional Budget Office has examined the committee's estimates (as shown in Part IV) and has submitted the following statements (one with respect to the revenue provisions and a separate one with respect to the spending provisions) with respect to the committee provisions.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., April 2, 1984.

Hon. ROBERT J. DOLE,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The Congressional Budget Office has examined the tax provisions adopted by the Committee on Finance on March 21, 1984. The provisions are in the form of a committee amendment to the reconciliation recommendations incorporated into S. 2062 last year. The amendment is in the nature of a substitute and consists of the original provisions included in S. 2062 and provisions agreed to during the course of subsequent committee deliberations.

The amendment contains both revenue and spending recommendations. A cost estimate of the spending provisions is being provided under separate cover. Titles I through VIII affect revenues. These titles are:

TITLE I—TAX REFORMS GENERALLY

Title I contains the bulk of the amendment's revenue raising measures. The title's many provisions fall into the following categories: (A) deferral of certain tax reductions, (B) tax-exempt entity leasing, (C) treatment of bonds and other debt instruments, (D) treatment of corporations and their shareholders, (E) partnership provisions, (F) trust provisions, (G) accounting changes, (H) provisions relating to tax straddles, (I) pension provisions, (J) foreign provisions, (K) tax compliance and administration provisions, (L) depreciation provisions, and (M) miscellaneous provisions.

TITLE II—LIFE INSURANCE TAX PROVISIONS

Title II provides new rules for the taxation of life insurance companies, replacing, among other things, the temporary life insurance provisions enacted in the Tax Equity and Fiscal Responsibility Act of 1982.

TITLE III—REVISION OF PRIVATE FOUNDATION PROVISIONS

Title III would modify rules for the tax treatment of private foundations and charitable contributions to foundations.

TITLE IV—ENTERPRISE ZONES

Title IV would provide for the designation of certain distressed areas as enterprise zones. Over three years, up to 75 areas may be designated by the Secretary of the Department of Housing and Urban Development as enterprise zones. Each enterprise zone is eligible for federal tax and regulatory relief designated to spur economic activity.

TITLE V—FOREIGN SALES CORPORATIONS

Title V would replace the existing export incentive that provides special treatment of export income earned by certain domestic subsidiaries (Domestic International Sales Corporations) of U.S. companies engaged in exporting. Title V would allow creation of Foreign Sales Corporations (FSCs), typically foreign incorporated subsidiaries of U.S. parent companies in the export business. The bill would exempt a portion of an FSC's export income from U.S. tax as long as certain criteria are met.

TITLE VI—HIGHWAY REVENUE PROVISIONS

Title VI would restructure the highway use tax to apply only to vehicles weighing 55,000 pounds or more, and to cap the tax at $600 per year. The tax on diesel fuel would be increased by 6 cents per gallon (the diesel differential) with a rebate of the diesel differential for vehicles weighing less than 10,000 pounds. Title VI would also make minor alterations to several other highway taxes.

TITLE VII—TAX-EXEMPT BOND PROVISIONS

The bill extends the authority of state and local governments to issue mortgage bonds for single-family housing for four years, until December 31, 1987. It also permits state and local governments to exchange mortgage bond authority in any year for authority to issue mortgage credit certificates. Finally, the bill imposes new restrictions on industrial bonds and on student loan bonds. The IDB restrictions include extension of the cost-recovery periods for IDB-financed property and prohibition of the use of small issues by firms with more than $40 million of outstanding tax-exempt debt. The student loan bond provisions include a requirement that issuers devote all profits from bond proceeds to the acquisition of additional loan notes under the issuer's loan program.

TITLE VIII—MISCELLANEOUS REVENUE PROVISIONS

Title VIII contains miscellaneous revenue provisions that fall into the following categories: (A) estate and gift tax provisions, (B) charitable provisions, (C) excise tax provisions, (D) employee benefits, (E) miscellaneous Treasury administrative provisions, (F) simplification and extension of income tax credits, (G) treatment of capital gains and losses, and (H) miscellaneous revenue matters.

The committee amendment would eliminate or reduce some tax expenditures and would create some new ones. On balance, it would reduce overall tax expenditures.

The CBO has reviewed and concurs with the estimates of the revenue effects of the bill's tax provisions prepared by the staff of the Joint Committee on Taxation. For scorekeeping purposes, CBO excludes the outlay effects of the earned income tax credit provision (under Title VIII, Miscellaneous Revenue Provisions) from the total revenue effects. These outlay effects are included in the separate CBO cost estimate of the bill's spending provisions.

Should the committee so desire, we would be pleased to provide further details on this estimate.

With best wishes.

Sincerely,

RUDOLPH G. PENNER, *Director.*

TABLE 1.—ESTIMATED NET REVENUE EFECTS OF TAX PROVISIONS OF COMMITTEE AMENDMENT TO S 2062, AS ADOPTED BY THE COMMITTEE ON FINANCE, FISCAL YEARS 1984-89

Provision	1984	1985	1986	1987	1988	1989
Title I Tax reforms generally	2,241	11,278	18,143	23,326	25,217	26,131
Title II Life insurance provisions	−120	−353	−397	−476	−529	−603
Title III Private foundation provisions	0	−21	−24	−26	−29	−32
Title IV Enterprise zones	(1)	(1)	(1)	(1)	(1)	(1)
Title V Foreign sales corporations	0	−43	−33	36	88	−98
Title VI Highway revenue provisions	−128	50	−69	−133	−42	−72
Title VII Tax-exempt bond provisions	−26	−114	−247	−401	−523	−503
Title VIII Miscellaneous revenue provisions [2]	510	−65	−834	−2,490	−3,185	−2,667
Total, tax provisions	2,477	10,634	16,119	19,061	19,980	21,105

[1] The budget effects of this provision will depend on the number, size, and characteristics of the enterprise zones designated by the Secretary of Housing and Urban Development. Grand totals in this table reflect Treasury Departmental estimates which show decreases of fiscal year budget receipts of $36 million in 1985, $420 million in 1986, $775 million in 1987, $1,017 million in 1988, and $1,051 million in 1989.

[2] Excludes outlay effect of earned income tax credit provision which would increase outlays by $5 million in 1985, $129 million in 1986, $170 million in 1987, $110 million in 1988, and $100 million in 1989.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, D.C., March 30, 1984.

Hon. ROBERT DOLE,
Chairman, Committee on Finance, U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for the spending provisions in the Senate Finance Committee Amendments to S. 2062, as approved by the Senate Committee on Finance on March 22, 1984.

Should the Committee so desire, we would be pleased to provide further details on this estimate.

Sincerely,

RUDOLPH G. PENNER, *Director.*

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: Unknown.
2. Bill title: Unknown.
3. Bill status: As approved by the Senate Committee on Finance on March 22, 1984.
4. Bill purpose: Unknown.

5. Estimated cost to the Federal Government: The estimated costs to the federal government are shown in Table 1.

TABLE 1.—ESTIMATED COST TO THE FEDERAL GOVERNMENT

(By fiscal year, in millions of dollars)

	1984	1985	1986	1987	1988	1989
DIRECT SPENDING						
Medicare						
Part B premium						
Budget authority	0	0	−384	−884	−1,507	−2,249
Outlays	0	0	−384	−884	−1,507	−2,249
Delay eligibility						
Budget authority	0	−10	1	19	24	44
Outlays	0	−145	−230	−255	−290	−325
Modify working age						
Budget authority	0	−28	−12	12	39	76
Outlays	0	−260	−380	−415	−455	−485
Freeze physicians' fees						
Budget authority	−217	−801	−964	−1,127	−1,295	−1,483
Outlays	−40	−750	−910	−1,070	−1,230	−1,410
Limit increase in hospital costs						
Budget authority	0	10	50	95	135	190
Outlays	0	−190	−430	−460	−390	−430
Fee schedule for clinical labs						
Budget authority	−116	−274	−344	−301	0	0
Outlays	−70	−255	−320	−400	0	0
Disallow revaluation						
Budget authority	0	5	10	30	45	75
Outlays	0	−50	−110	−170	−220	−280
SNF reimbursement						
Budget authority	−1	−4	−8	−12	−17	−23
Outlays	20	30	35	40	45	50
Round down part B payments						
Budget authority	−27	−67	−72	−78	−88	−99
Outlays	−15	−65	−70	−75	−85	−95
Competitive bidding						
Budget authority	0	−14	−20	−27	−29	−28
Outlays	0	−15	−25	−35	−40	−40
Lesser of costs or charges						
Budget authority	0	5	15	25	35	50
Outlays	0	−80	−90	−105	−120	−140
Hepatitis B vaccine						
Budget authority	(1)	(1)	(1)	−2	−4	−4
Outlays	3	−1	−2	−2	−4	−4
Limit foot care						
Budget authority	−6	−11	−11	−12	−13	−14
Outlays	−5	−11	−11	−12	−13	−14
Index part B deductible						
Budget authority	0	−50	−95	−105	−115	−125
Outlays	0	−35	−90	−100	−110	−120
Copayment for DME						
Budget authority	1	2	5	8	11	14
Outlays	−10	−20	−25	−25	−30	−30
Transfers to HI						
Budget authority	0	1,000	1,600	2,400	2,800	3,700
Outlays	0	0	0	0	0	0
Medicaid						
Extend medicaid penalties						
Budget authority	0	−562	−353	−432	210	0
Outlays	0	−562	−353	−432	210	0
Assignment of rights						
Budget authority	0	−7	−7	−8	−9	−10
Outlays	0	−7	−7	−8	−9	−10

TABLE 1.—ESTIMATED COST TO THE FEDERAL GOVERNMENT—Continued

[By fiscal year, in millions of dollars]

	1984	1985	1986	1987	1988	1989
Increase reimbursement for Puerto Rico:						
Budget authority	20	20	20	20	20	20
Outlays	20	20	20	20	20	20
Pregnant women:						
Budget Authority	4	11	12	13	14	15
Outlays	4	11	12	13	14	15
Recertification of SNF and ICF:						
Budget authority	−3	−4	0	1	1	1
Outlays	−3	−4	0	1	1	1
Psychiatric hospitals:						
Budget authority	5	10	6	3	0	0
Outlays	5	10	6	3	0	0
Other						
Medicare effect on medicaid:						
Budget authority	−19	−74	−57	−29	85	134
Outlays	−19	−74	−57	−29	85	134
Medicare effect on premiums:						
Budget authority	0	223	310	335	341	376
Outlays	0	223	310	335	341	376
Medicaid effect on medicare:						
Budget authority	1	3	6	10	13	17
Outlays	−13	−27	−29	−31	−33	−35
AFDC						
Expand filing unit:						
AFDC:						
Budget authority	−35	−135	−140	−145	−150	−155
Outlays	−35	−135	−140	−145	−150	−155
Offsets—medicaid:						
Budget authority	20	80	90	100	110	120
Outlays	20	80	90	100	110	120
Require minor parent to live with parents:						
AFDC:						
Budget authority	−5	−20	−20	−20	−20	−20
Outlays	−5	−20	−20	−20	−20	−20
Offsets—medicaid:						
Budget authority	(1)	−5	−5	−5	−5	−5
Outlays	(1)	−5	−5	−5	−5	−5
Clarify definition of earned income:						
Budget authority	−8	−24	−24	−24	−24	−24
Outlays	−8	−24	−24	−24	−24	−24
Permit CWEP work for Federal agencies:						
Budget authority	(1)	(1)	(1)	(1)	(1)	(1)
Outlays	(1)	(1)	(1)	(1)	(1)	(1)
Exclude earned income of children who are full-time students:						
Budget authority	(1)	(1)	(1)	(1)	(1)	(1)
Outlays	(1)	(1)	(1)	(1)	(1)	(1)
SSI						
Eliminate windfall benefits:						
Budget authority	(1)	−12	−17	−18	−19	−20
Outlays	(1)	−12	−17	−18	−19	−20
YASDI						
Church employees:						
Budget authority	−51	−17	−16	−11	−14	−11
Outlays	0	0	0	0	0	0
IRS						
Income verification:						
Budget authority	0	5	−310	−360	−380	−410
Outlays	0	31	−300	−391	−411	−441
Offset debts—IRS:						
Budget authority	0	0	−300	−500	−700	−900

TABLE 1.—ESTIMATED COST TO THE FEDERAL GOVERNMENT—Continued

[By fiscal year, in millions of dollars]

	1984	1985	1986	1987	1988	1989
Outlays	0	0	−300	−500	−700	−900
Require Treasury—Cash management:						
Budget authority	0	0	−800	−800	0	0
Outlays	0	0	−800	−800	0	0
Puerto Rican excise tax:						
Budget authority	0	−305	−333	−357	−362	−364
Outlays	0	−305	−333	−357	−362	−364
Earned income tax:						
Budget authority	0	5	129	120	110	100
Outlays	0	5	129	120	110	100
Total direct spending:						
Budget authority	−437	−1,045	−2,038	−2,066	−758	−1,012
Outlays	−151	−2,642	−4,860	−6,136	−5,291	−6,780
Authorizations						
Maternal and child health block grant:						
Authorization	53	26	1	−28	−61	−96
Outlays	33	30	12	−14	−45	−78
Sport fish restoration program:						
Authorization	0	28	29	30	30	31
Outlays	0	7	15	21	25	29
Food stamps:						
Offsetting effect of AFDC and SSI programs:						
Authorization	15	52	54	59	60	62
Outlays	15	52	54	59	60	62
Total authorization:						
Authorization	68	106	84	61	29	−3
Outlays	48	89	81	66	40	13
Total						
Authorization/budget authority	−369	−939	−1,954	−2,005	−729	−1,015
Outlays	−103	−2,553	−4,779	−6,070	−5,251	−6,767

(1) Less than $500,000

Basis of estimate

We have assumed an enactment date of May 1984 for the purpose of estimating provisions that would become effective upon enactment.

The authorization estimates are shown as changes from the CBO baseline. The estimates assume corresponding appropriation action.

The estimates are based on preliminary draft language and on Committee descriptions of the proposals. Since final language was not available, the estimates should be considered preliminary.

The estimates include the provisions in the spending title. Also included are spending estimates for provisions included in the tax title that have spending implications.

6. Estimated cost to State and local governments: The estimated change to State and local budgets result from several major provisions. The income verification proposal would result in state savings in AFDC, SSI, and Medicaid. Changing the AFDC filing unit would result in state savings in AFDC and state costs in Medicaid. Additional state Medicaid costs would also result from the extension of the Medicaid penalties. The net estimated cost to state and local budgets is shown below.

[By fiscal year, in millions of dollars]

	1984	1985	1986	1987	1988	1989
Estimated State and local costs	−70	380	0	75	−470	−235

7. Estimate comparison: None.
8. Previous CBO estimate: None.
9. Estimate prepared by: Diane Burnside, Hinda Ripps Chaikind, Mary Ann Curtin, Robert Lucke, Janice Peskin, Jack Rodgers, and Robert Sunshine.
10. Estimate approved by:

C. G. NUCKOLS
(For James L. Blum,
Assistant Director for Budget Analysis).

Tax expenditures

In compliance with section 308(a)(2) of the Budget Act, with respect to tax expenditures, and after consultation with the Director of the Congressional Budget Office, the committee states that the bill, on balance, reduces total tax expenditures. The provisions that reduce the minimum holding period required for long-term capital gain treatment, extend certain energy tax credits, provide for enterprise zones, and make permanent the research and equipment donation credits increase tax expenditures. Generally, the other provisions in the bill reduce tax expenditures or are neutral in their effect on tax expenditures. More detailed information is presented in the discussions of the specific provisions in Part V, Explanation of Provisions, and in Part IV, Revenue Effects of Tax Provisions (Table IV-2).

○